NEBRASKA COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT
"Nebraska State Plan Implementation Report for FY2005"

Nebraska Department of Health and Human Services
Division of Behavioral Health Services

The Nebraska State Plan Implementation Report is prepared to address the requirements under Section 1942(a) of the PHS Act (42 U.S.C. 300x-52). This report is due to the U.S. Department of Health & Human Services / Center for Mental Health Services (CMHS) by December 1, 2004. The State Advisory Committee on Mental Health Services (State Mental Health Planning Council) reviewed the report on November 10, 2004. Send questions or comments on this report to:

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PART D: IMPLEMENTATION REPORT

SECTION ONE: FY2005 PURPOSES BLOCK GRANT EXPENDED, BY SERVICE TYPE AND RECIPIENTS OF FUNDS

Use of Federal Mental Health Block Grant in FY2005

This is a report on the purposes for which the block grant monies for State FY2005 were expended, the recipients of grant funds, and a description of activities funded by the grant.

- **Purpose** – the funds were used in two ways. (1) the primary purpose was to purchase community mental health services. (2) the 5% administrative portion was used to support Adult Goal #3: Empower Consumers.

- **Recipients of Grant Funds** - the six Regional Behavioral Health Authorities were the recipients of the funds. A small amount is used to fund Rural Service Equity. Rural Service Equity are funds allocated as needed to rural areas.

  The "Nebraska Behavioral Health Services Act" (LB1083) sections 7-9 revised the regional administration of the system. LB1083 retained the six geographic “regions” established in 1974. LB1083 re-authorized the six regions and renamed them “Regional Behavioral Health Authorities” (RBHA). The RBHA are local units of government organized under the Interlocal Cooperation Act for the purpose of planning, organizing, staffing, directing, coordinating and reporting of the local service systems of mental health, and substance abuse within assigned geographic areas (regions). There are six Regional Behavioral Health Authorities in Nebraska. Each county participating in the region appoints one county commissioner to the Regional Governing Board to represent that county and to participate in the decision making of the Regional Behavioral Health Authority (RBHA). The RBHA is staffed by the Regional Program administrator who in turn hires sufficient staff to accomplish the tasks within the region. RBHA contracts with local providers for service delivery.

- **Expended / Description of Activities** - the table below shows how the funds were expended with a brief description of services funded by the grant.

Summary

actually expended in FY2005	$1,965,439
state administration (Empower Consumers)	$104,308
peer review	$5,000
balance in Rural Service Equity fund	$11,412
total fy2005 award	$2,086,159

FY2005 Actuals / Federal Mental Health Block Grant

Adult Services	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Totals	% of Total
NON-RESIDENTIAL SERVICES								
L 1 – Day Treatment – MH					$20,000		$20,000	1.8%
L 4 – Outpatient Therapy - MH (Ind/Grp/Fam)	$29,419		$37,255	$31,520	$144,000	$192,833	$435,027	39.7%
L 4 – Outpatient Therapy - Dual (Ind/Grp/Fam)	$6,032		$9,748				$15,780	1.4%
L 5 – Medication Management – MH		$40,504	$53,918			$72,710	$167,132	15.3%
L 5 – Day Support – MH	$33,360		$43,651				$77,011	7.0%
L 5 – Vocational Support – MH	$1,440		$15,534	$26,928			$43,902	4.0%
Day Rehabilitation		$57,023				$62,809	$119,832	10.9%
Dual Residential (SPMI/CD)					$15,000		$15,000	1.4%
Psych Residential Rehab						$87,636	$87,636	8.0%
Community Support – MH		$54,682	$15,240	$30,616		$11,558	$112,096	10.2%
Capacity Access Guarantee / Community Support				$2,331			$2,331	0.2%
Adult Totals	$70,251	$152,209	$175,346	$91,395	$179,000	$427,546	$1,095,747	100%
% of Total Federal on Adult Services	37.7%	91.0%	65.4%	33.7%	40.8%	67.4%	55.8%	
Children/Youth Services								
Professional Partner - School WRAP	$78,000			$83,850			$161,850	18.6%
Professional Partner			$50,000	$80,000	$150,921	206,437	$487,358	56.0%
C/Y Day Treatment	$38,000		$42,856				$80,856	9.3%
C/Y Intensive Outpatient – MH				$1,136	$35,838		$36,974	4.3%
C/Y MH Therapeutic Consult					$73,000		$73,000	8.4%
Federal Children's Set Aside / P.L.100-690		$15,000		14,654			$29,654	3.4%
Youth Totals	$116,000	$15,000	$92,856	$179,640	$259,759	$206,437	$869,692	100%
% of Total Federal on Youth Services	62.3%	9.0%	34.6%	66.3%	59.2%	32.6%	44.2%	
GRAND TOTAL MH $ - Report of Actual	$186,251	$167,209	$268,202	$271,035	$438,759	$633,983	$1,965,439	100%

Source: Nebraska Division of Behavioral Health Services; as reported by the Regional Behavioral Health Authorities / September 2005

DESCRIPTION OF ACTIVITIES / ADULT SERVICES

- Day Treatment – Specialized medically based day program for persons with serious mental illness that enables a person to live independently and still attends an intensive program including assessment, individual, family and group therapy, and medication services as developed by a multidisciplinary team. Programming usually involves 6-8 hours of activity per day/6-7 days per week. Length of service varies depending on individual needs but is usually not longer than 21-45 days.
- Outpatient/Assessment – Assessment, diagnosis and psychotherapy/counseling for a variety of mental health problems which disrupt individual's life that includes counseling and talk therapy treatment to change behavior, modify thought patterns, cope with problems, improve functioning; may include coordination to other services to achieve successful outcomes. Length of service varies depends on individual illness and response to treatment but averages 10 sessions at least once per week. Group therapy sessions include approximately 3-8 persons. Family counseling are included in this service level.
- Medication Management – Prescription of appropriate psychotropic medication (usually, but not limited to persons with severe and persistent mental illness), and follow-up to therapeutic response, including identification of side effects. Medication checks usually take 15-30 minutes with the psychiatrist, an/or a nurse or case manager.
- Day Support (Drop-In Center w/Peer Support) -- Facility based program for persons with severe and persistent mental illness. This transition "drop-in" center for persons who have not yet enrolled in Day Rehabilitation, or who have completed their rehab plan in the Day Rehab service and want to continue to socialize with friends they have made at the Day Rehab service is designed to engage consumers. This service does not require a service plan but provides an environment to be with other people who share the same life and illness situation. Persons with severe and persistent mental illness are hired as peer specialist staff in this program. Additional support including outreach are the main focus of this drop in center. Pre-Day Rehab consumer length of stay may be 3-6 months. Post-Day Rehab consumer length of service is very individualized and may range from 6 months – 5+ years.
- Vocational Support – Ongoing support for persons with severe and persistent mental illness after they have secured long term employment. The support activities general take place off the job site, but can include assistance in learning job duties, problem solving and other job functions in order for individual to maintain gainful employment. Length of service depends on individual consumer need but is usually not longer than 6-24 months.
- Day Rehabilitation – Facility based day program for a person with severe and persistent mental illness that focuses on psychosocial rehabilitation after treatment has stabilized the mental illness. Provides prevocational and transitional employment services, planned socialization, skill training in activities of daily living, medication management, and recreation activities are focused on returning a person to work and maintaining independence in the community. Programming usually involves 5 hours of activity per day/5 days per week and some weekends. Length of service varies depending on individual needs but is usually not longer than 6 months – 5 years.
- Dual Residential -- Facility based program that provides simultaneous integrated treatment for individuals with severe and persistent mental illness and chemical dependence. Includes medication management and psychosocial rehab as well as treatment for stabilization and recovery. Substance abuse and mental health professionals staff the service. Substance abuse and mental health treatment are integrated. Length of service varies depending on individual needs but is not longer than 4-8 months.

- Residential Rehabilitation (Psych Res Rehab) – 24 hour, residential facility in the community for persons with severe and persistent mental illness. Persons in this service need the 24-hour structured psychosocial rehabilitation and medication management to regain or relearn skills that will allow them to live independently in their communities. Length of service varies depending on individual needs but is not longer than 4-8 months. Length of service varies depending on individual needs but is usually not longer than 9-18 months.
- Community Support – With 24 hour, 7-day/week availability, provides consumer advocacy, ensures continuity of care, active support in time of crisis, provides direct skill training in the residence and community, provide or arrange for transportation, arrange for housing, acquisition of resources and assistance in community integration for individuals with severe and persistent mental illness. Length of service varies depending on individual needs but is usually not longer than 6 months – 2 years.

DESCRIPTION OF ACTIVITIES / CHILDREN/YOUTH SERVICES

- Professional Partner – Strength-based, family centered approach to working with children with serious emotional disturbances and their families. Access to services on a 24-hour, 7day/week basis. Uses a wraparound approach to coordinate services and supports to families. Includes coordinated assessment, flexible funding to provide support, based on needs as outlined by a multidisciplinary team. Emphasizes family empowerment and involvement in planning.
- School Wraparound – In this variation of the Professional Partner Program, a special education teacher, team teacher, or school social worker works with the Professional Partner and the Child and Family Team to coordinate the school plan. Based on the LaGrange Area Department of Special Education (LADSE) approach in LaGrange, Illinois, a team of two wraparound service coordinators are based in the school. Planning efforts around the child and family create an environment in which the school is an integral part of the overall assessment and support for the child and his/her family. This School-Based Wraparound Approach allows the teacher and/or other school personnel to feel comfortable voicing classroom based concerns (academic and behavioral) and members of the Child and Family Team are also able to understand these concerns. The two individuals work closely together as a team to assist and coordinate services to a combined caseload of approximately 20 children/families. Both individuals bring specific strengths to the team from their varied backgrounds in the school and in the community.
- Day Treatment – Facility based program serving children and adolescents with Severe Emotional Disturbance. Intensive, non-residential service providing counseling and family services, education, behavior modification and skill building, promoting reintegration back to the child's regular school.
- Outpatient/Assessment – Assessment, diagnosis and psychotherapy/counseling for mental health problems which disrupt a youth's home, school, family functioning; treatment focuses on changing behavior, modifying thought patterns, coping with problems, improving functioning and may include coordination to other services to achieve successful outcomes. Length of service varies depending on individual needs but is usually not longer than 10 sessions no more than once per week.
- Therapeutic Consultation – Collaborative, clinical intervention for youth with early indications of Severe Emotional Disturbance. Multidisciplinary based interventions with family, teachers and mental health professional involvement in the school or other natural setting.

PART D: IMPLEMENTATION REPORT

SECTION TWO:
SUMMARY OF SIGNIFICANT EVENTS
SIGNIFICANT ACHIEVEMENTS IN ITS PREVIOUS FISCAL YEAR

GOVERNOR

On December 2, 2004, President Bush announced his nomination of Governor Mike Johanns to be the Secretary of the U.S. Department of Agriculture. At the time, Governor Johanns was midway through his second four-year term. On January 20, 2005 Governor Johanns resigned in order to assume his new duties as Secretary of Agriculture. As a result of this gubernatorial resignation, on January 20, 2005 Dave Heineman became Nebraska's 39th governor.

Governor Mike Johanns made his State of the State address on January 15, 2004. He included statements on his vision for the future such as,

> "We have worked directly with citizens who have mental illnesses and they have moved and impressed me. They are not weak people; they are not troubled people; they are people who have an illness. They merely seek understanding as they work daily toward their recovery. With treatment, many are undaunted by the burden of their illness only to be held back by a stigma that has no rightful place in our society today, yet sadly continues. It is time to open the doors and shine light on the dramatic advances in treatment."

Governor Dave Heineman, in his State of the State Address on January 26, 2005 to the Nebraska Legislature said,

> "My budget provides funding to build upon the very impressive progress that has already been made toward expanding behavioral health services across our state and bringing treatment closer to home. You have brought new meaning to the lives and futures of thousands of Nebraskans who view your passage of LB1083 as a declaration of their value and an invitation to contribute to their communities."

POLICY CABINET:

The Nebraska Health and Human Services System (HHSS) Policy Cabinet governs this State of Nebraska agency. The Policy Cabinet consists of the three agency directors, a Policy Secretary, and the Chief Medical Officer. The Governor appoints the HHSS Policy Cabinet. As of July 2005, the HHSS Policy Cabinet is Chris Peterson (Policy Secretary and HHS Regulation & Licensure Interim Director); Dick Nelson (Director, HHS Finance & Support); Nancy Montanez (Director, Health & Human Services) and Blaine Shaffer, M.D.

Over the last year, there have been some changes to the HHSS Policy Cabinet. Steve Curtiss, Director, NE Department of Health and Human Services Finance & Support resigned. Dick Nelson, Director, NE Department of Health & Human Services Regulation & Licensure, was appointed to serve as Director of Finance and Support. Dr. Richard Raymond, the Nebraska's Chief Medical Officer, was appointed to serve as Director of Regulation and Licensure.

In July 2005, Dr. Richard Raymond was confirmed as Undersecretary for Food Safety at the U.S. Department of Agriculture. His last day was July 18, 2005. Governor Dave Heineman appointed Dr. Joann Schaefer as Director of the Nebraska Department of Health and Human Services Regulation and Licensure and the state’s Chief Medical Officer in September 2005.

BEHAVIORAL HEALTH ADMINISTRATOR & CHIEF CLINICAL OFFICER

- Neb. Rev. Stat. 71-805 (2) created a new position of Behavioral Health Administrator. The Administrator is appointed by the Governor and confirmed by a majority of the members of the Legislature. On September 17, 2004, Governor Johanns announced the appointment of Richard DeLiberty of Carmel, Indiana to the position of Behavioral Health Administrator. On March 22, 2005, Richard DeLiberty resigned. On March 23, 2005, Governor Heineman named Ronald Sorensen, Deputy Administrator of the Division of Behavioral Health Services, as Nebraska's interim Behavioral Health Services Administrator. On July 27, 2005, Governor Dave Heineman appointed Ronald Sorensen to serve as the Behavioral Health Services Administrator for the State of Nebraska.
- On January 13, 2005, Blaine Shaffer, M.D., was appointed to the position of Chief Clinical Officer for the Division of Behavioral Health Services in the Department of Health and Human Services (HHS). The Nebraska Behavioral Health Services Act, Neb. Rev. Stat. 71-805 (2), created the position of chief clinical officer. The statute requires the chief clinical officer to be a board-certified psychiatrist and to serve as the medical director for the division and all facilities and programs operated by the division.

NEBRASKA BEHAVIORAL HEALTH SERVICES ACT

Major changes continue to take place in Nebraska. The **Nebraska Behavioral Health Services Act,** Neb. Rev. Stat. §§ 71-801 to 71-820 (Laws 2004, LB 1083, §§ 1 – 20) was approved by the Governor on April 14, 2004. The **"Nebraska Behavioral Health Services Act"** represents a major reform of the Nebraska Behavioral Health System. For example, § 71-804 (2) defines a "Behavioral Health disorder" as "mental illness or alcoholism, drug abuse, problem gambling, or other addictive disorder". The Nebraska Behavioral Health Services Act establishes a revised framework for the provision of behavioral health services in Nebraska. For more information on the Nebraska Behavioral Health Services Act and the Nebraska's Behavioral Health Reform Initiative, visit the Nebraska Health and Human Services web site and click on "Adult Behavioral Health Reform" **<http://www.hhs.state.ne.us/beh/reform/>**.

REGIONAL CENTERS

HHS is a direct service provider of mental health services through three State Psychiatric Hospitals (Hastings Regional Center, Lincoln Regional Center, Norfolk Regional Center). One of the intents of the Act is to reduce the necessity and demand for regional center services. Here are some examples from the Act demonstrating this intent: 71-802 (7) says one of the purposes of the Nebraska Behavioral Health Services Act is to "authorize the closure of regional centers". 71-810 (1) (b) calls for "reducing the necessity and demand for regional center behavioral health services." and 71-810 (2) says, "The division may reduce or discontinue regional center behavioral health services only if (a) appropriate community-based services or other regional center behavioral health services are available for every person receiving the regional center services that would be reduced or discontinued, (b) such services possess sufficient capacity and capability to effectively replace the service needs which otherwise would have been provided at such regional center, and (c) no further commitments, admissions, or readmissions for such services are required due to the availability of community-based services or other regional center services to replace such services. 71-810 (5) says " The division may establish state-operated community-based services to replace regional center services".

Mechanism to Close a Regional Center

The Nebraska Behavioral Health Systems Act will eventually close the regional centers in Hastings and Norfolk to create more community-based programs for treating behavioral health disorders. In §71-810, the Act provides key directions for the changing of the Behavioral Health System in Nebraska

- (1) instructs the Division to encourage and facilitate the Statewide development and provision of an appropriate array of Community-Based Behavioral Health Services and continuum of care.
- (2) says the Division may reduce or discontinue Regional Center Behavioral Health services only if appropriate community-based services or other Regional Center Behavioral Health services are available for every person receiving the Regional Center services that would be reduced or discontinued.
- (6) says the division is to notify the Legislature and Governor when occupancy of the licensed psychiatric hospital beds of any Regional Center reaches 20% or less of its licensed psychiatric hospital bed capacity on March 15, 2004. The Legislature's Executive Board may grant the division permission to close the center and transfer any remaining patients to appropriate community-based services.
- (7) states that the provisions of Section 10 are self-executing and require no further authorization or other enabling legislation.

COMMUNITY MENTAL HEALTH

Under the Nebraska Behavioral Health Services Act; Neb. Rev. Stat. 71-801 to 71-820 (Laws 2004, LB 1083, §§ 1 – 20) the Division of Behavioral Health Services was formed. The primary role involves State administration and management of non-Medicaid public behavioral health services through Regional and direct service contracts. In that capacity, the Division provides a state leadership role as the Mental Health Authority and State Substance Abuse Authority. Key sections under the statute assigning duties to the Division of Behavioral Health Services are

71-804 (8) Division means the Division of Behavioral Health Services of the department;
71-805 Division of Behavioral Health Services; established; personnel; office of consumer affairs.
71-806 Division; powers and duties; rules and regulations
71-806 (1) The Division of Behavioral Health Services shall act as the chief Behavioral Health authority for the State of Nebraska.
71-810 Division; community-based behavioral health services; duties; reduce or discontinue regional center behavioral health services; powers and duties.
71-811 Division; funding; powers and duties.
71-812 Behavioral Health Services Fund; created; use; investment.
71-813 State Behavioral Health Council
71-814 State Advisory Committee on Mental Health Services
71-815 State Advisory Committee on Substance Abuse Services
71-816 State Advisory Committee on Problem Gambling and Addiction Services
71-817 Compulsive Gamblers Assistance Fund; created; use; investment.
71-916 Mental health commitment board training

Starting in 1995, there has been a Medicaid managed care contract for mental health and a separate contract for behavioral health. Magellan Behavioral Health handles the Managed Care Administration Service Organization (ASO) Mental Health and Substance Abuse (MH/SA) services contract. Magellan Behavioral Health (Magellan) covers both Medicaid (Managed Care Program and Medical Assistance Program) and the Nebraska Behavioral Health System (NBHS). The contracts cover a three year time period, and a possible three year extension. The Medicaid portion of this started July 1, 2002. This contract was converted to the ASO format. The Nebraska Behavioral Health System (NBHS) contract started January 1, 2003. The Nebraska Health and Human Services Policy Cabinet recently approved a three year extension to the Magellan contract covering FY2006, FY2007 and FY2008.

ASO Contract & Data Collection - The data base used for community behavioral health programs was moved to Magellan Behavioral Health during the first contract cycle. Community based data collection by Magellan was implemented on July 1, 1997 and community-based utilization management was initiated in December of 1997 for those services requiring authorization.

The contract covering Nebraska Behavioral Health System (NBHS) includes the Magellan Behavioral Health data system. Revisions were implemented in October 2003. The revised 117 data fields for the NBHS cover Community mental health, community substance abuse, and the gamblers assistance program. Sections such as demographics, admission status data, children/adol (0-18), history of substance abuse, service / authorization, financial eligibility, discharge status.

Nebraska's Behavioral Health Reform Initiative

For the last several years, Governor Mike Johanns has publicly stated that behavioral health reform was his priority.

- LB 724 (2003): Established a “roadmap” for reform of the public behavioral health system and outlined focus areas for reform.
- LB 710 (2003): Proposed recodification of the Nebraska Mental Health Commitment Act.
- LB 1083 (2004): Implemented the Nebraska Behavioral Health Reform intent.

New developments and issues

LB 40 (2005) amended Neb. Rev. Stat. § 71-812 (Behavioral Health Services Fund) to authorize the use of state funds to provide Housing-related assistance for very low-income adults with serious mental illness. The act became operative on July 1, 2005. LB40 deleted Rental assistance for adults with serious mental illness under LB1083 (2004) section 101. Housing-Related Assistance includes rental payments, utility payments, security and utility deposits, and other related costs and payments.

LB40A appropriated $1,845,000 to be distributed to each regional behavioral health authority on a per capita basis no later than thirty days after receipt of such funds and shall only be used for one-time funding for new construction, acquisition, or rehabilitation of housing to assist very low-income adults with serious mental illness. Below is the allocation chart used for FY2006.

	Housing Related Assistance	LB40A One Time Funding	Total FY2006 Allocations	Percentage
1	$88,100	$97,785	$185,885	5.0%
2	$88,100	$110,700	$198,800	5.4%
3	$268,600	$239,850	$508,450	13.7%

4	$268,600	$232,470	$501,070	13.5%
5	$444,800	$446,490	$891,290	24.1%
6	$696,800	$717,705	$1,414,505	38.2%
Rg Total	$1,855,000	$1,845,000	$3,700,000	100.0%
reserve	$145,000			
Total fund	$2,000,000			

The Division prepared "State Rental Assistance Transition Voucher Program Guidelines For the Implementation of the Housing Related Assistance for Adults with Serious Mental Illness" in order to implement the requirements of LB40 "in a manner consistent with and reasonably calculated to promote the purposes of the public behavioral health system enumerated in section 71-803." Those guidelines are now posted on the HHSS web site (see http://www.hhs.state.ne.us/beh/Housesum.htm).

LB 551 (2005) changed provisions relating to behavioral health services in a number of ways including establishing a data and information system reporting duties for the Division of Behavioral Health Services. LB 551 requires the Division of Behavioral Health Services, in consultation with each regional behavioral health authority, to establish and maintain a data and information system for all persons receiving state-funded behavioral health services. LB 551 also requires the division to submit reports of the information to the Governor and Legislature on a quarterly basis beginning July, 2005.

LB 709 Adopt the Medicaid Reform Act (2005) provides legislative findings relating to the increased expenditures of Medicaid. Also, the Legislature finds that the Medicaid program provides essential health care and long-term coverage to low-income children, pregnant women and families, individuals with disabilities, and senior citizens serving over one in ten Nebraskans. The purpose of the act is to provide for reform of the Medicaid program and a substantive recodification of statutes relating to this program, including, but not limited to, the enactment of policies to 1) moderate the growth of Medicaid spending, 2) ensure future sustainability of the Medicaid program for Nebraska residents, 3) establish priorities and ensure flexibility in the allocation of Medicaid benefits, and 4) provide alternatives to Medicaid eligibility for Nebraska residents.

Under the Nebraska Behavioral Health Reform, the Medicaid Rehabilitation Option (MRO) claims payment function has been transferred from the Division of Behavioral Health Services to Medicaid starting July 1, 2005.

ASAM & MEDICAID

Division of Behavioral Health Services and Medicaid adopted "American Society of Addiction Medicine" (ASAM) Standards for use in the implementation of the 1915B Waiver for Adult Substance Abuse services. The "ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders" (2001) is a clinical guide used for matching patients to appropriate levels of care. The criteria reflect a clinical consensus of adult and adolescent treatment specialist that incorporate field review comments. The purpose of the criteria is to enhance the use of multidimensional assessments in making objective patient placement decisions for various levels of care. There are adult patient placement criteria and adolescent patient placement criteria. This is part of the appropriate development of services to address "co-occurring mental and substance-related disorders", consistent with the Diagnostic and Statistical Manual of Mental Disorders.

PART D: IMPLEMENTATION REPORT
SECTION TWO:

REVIEW OF CRITICAL GAPS / UNMET NEEDS

AREAS WHICH THE STATE IDENTIFIED IN THE PRIOR FISCAL YEAR'S APPROVED PLAN AS NEEDING IMPROVEMENT

GAP #1: THE DISCREPANCY BETWEEN PREVALENCE OF MENTAL ILLNESS AND NUMBER OF INDIVIDUALS SERVED BY SYSTEM.
UPDATE – November 2005

The prevalence of mental illness is the estimated total number of cases of a disease in a given population at a specific time. The penetration rate is the number of individuals with these diseases being served by the public and private sectors in Nebraska. The data presented below uses the Nebraska Implementation Report 2004 for the Federal Uniform Reporting System.

	Table 1	table 2A	table 14
		Total	Total (SED)
Children			
0-3 Years		179	84
4-12 years		595	37
13-17 years		1,002	152
Total Children	22,146	1,776	273
Adults			Total (SMI)
18-20 years		1,062	231
21-64 years		15,014	6,336
65-74 years		342	176
75+ years		195	71
Total Adults	70,480	16,613	6,814
Not Available		7	2
Total		18,396	7089

SMI – Adults with Serious Mental Illness
SED – Children with Serious Emotional Disturbances

- Table 1 (to be reported in December 2005) – The Federal Center for Mental Health Services estimated for 2004 that Nebraska has 70,480 adults with serious mental illness and 22,146 Children with Serious Emotional Disturbances. Source: State Data Infrastructure Coordinating Center, National Association of State Mental Health Program Directors Research Institute, Inc. (NRI) under contract with the Federal Center for Mental Health Services (CMHS) (contract no. 280-99-0504) August 2005. http://www.nri-inc.org/SDICC/SDICC05/05files.cfm
- Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity Unduplicated data using all Magellan Behavioral Health (MH, SA, Dual) and AIMS (Regional Centers). AIMS means Advanced Institutional Management Systems; state fiscal year (July 1, 2003 to June 30, 2004); services in programs provided or funded by the state mental health

agency (HHS Division of Behavioral Health Services); all institutional and community services; The Adult data do not include Medicaid or any other publicly funded behavioral health services; the Children data do not include the services provided by the HHS Protection and Safety nor Medicaid.

- Table 14A. Profile of Persons with SMI/SED served by Age, Gender and Race/Ethnicity: Table 14 uses the same data as Table 2A, sorted by SMI and SED; SMI includes - Axis I Diagnosis 295 to 298.9 AND Axis V less than 60 (GAF SCORE); SED Axis I of 295 through 298.9 only - no other criteria other than age less 18 yrs.

Regarding Children, services in the public system are primarily available to specific target groups, including children who are state wards, children who are involved in the legal system, and children with families with no insurance or financial resources. This gap in service exists primarily because the need is great and funding resources are limited. Therefore, funds have been targeted to provide services for very specific groups of children and their families. Unfortunately, one way to access services for children is for parents to relinquish custody of their children, deeming them state wards, and making them eligible for services. Another circumstance is allowing children to fail to the point where they violate the law. Children then fall into one of the designated service categories and are able to access services. This is not an acceptable state of affairs. Appropriate service models are effective and available, but without adequate funding to serve children in need, Nebraska will continue to pay the price later by forcing children into higher levels of care and/or into the legal system.

Unfortunately, Nebraska does not have the capacity to determine the penetration rate of all systems for children with serious emotional disturbance. Because a number of systems (Nebraska Behavioral Health System, Medicaid, Office of Protection and Safety, including child welfare and Juvenile Justice, Education and Corrections) may provide some sort of mental health service for children with SED and their families, it is difficult to gather data as to an unduplicated count of children receiving services. An information system is not available which is able to synthesize data on children receiving services across multiple systems; data is not available on the number of children not receiving services. Given the anecdotal data which indicates a large number of children needing services are not receiving them, one might theorize that some populations of children may be “over-served” while others remain unserved because they are outside the eligibility boundaries of child serving systems with adequate funding for mental health care.

The Nebraska Behavioral Health System (NBHS) is the publicly funded, non-Medicaid program. Calculation of the penetration rate is limited to those served within NBHS and reported on the Magellan Behavioral Health Information System. The penetration rate should be the number of children with this diagnosis receiving services through the Nebraska Behavioral Health System (NBHS), Office of Protection and Safety System, including Child Welfare and Juvenile Justice Systems, and others receiving services funded by Medicaid or private insurance. Most significantly, the lack of complete penetration data makes it difficult to plan for services for children when the gaps are not readily apparent.

Regarding Adults, in looking at these figures, it is important to remember that the persons served data from FY2004 is limited to the Nebraska Behavioral Health System (NBHS). NBHS is the publicly funded, non-Medicaid program. It is also important to remember the role of Medicaid, the Criminal Justice System, the private sector (health insurance and self pay) and other related areas in addressing the needs of these populations. Thus the gap here involves two areas:

1. Nebraska's capacity to determine the Prevalence and Penetration rate for adults with mental illness.
2. The gap between the actual number of persons in need (prevalence) and the NBHS capacity to meet these needs (penetration rate).

GAP #1: THE DISCREPANCY BETWEEN PREVALENCE OF MENTAL ILLNESS AND NUMBER OF INDIVIDUALS SERVED BY SYSTEM.
CHILDREN
UPDATE – November 2005

Nebraska has been granted a state infrastructure grant to support systems of care at the state level. According to the grant proposal, although some Nebraska communities have developed comprehensive, integrated systems of care that provide exceptional services for children and families, these efforts are islands of excellence in a troubled sea. The State has significant challenges in appropriately addressing the behavioral health needs of its children and their families. Vast areas of the state are frontier and rural and have severe shortages of mental health and substance abuse professionals. Of Nebraska's 93 counties, 86 are designated psychiatric shortage areas. Even when services are available, families have difficulty affording behavioral healthcare; Nebraska has seven of the 12 poorest counties in the nation. According to an Omaha World Herald expose' on children's mental health, one in four families of children with serious mental health problems were encouraged to relinquished custody of their child just to access behavioral healthcare that they could not afford; Nebraska has the highest number of children per capita in the country who are wards of the state. Nebraska has a growing population of ethnic/racial minorities; these populations present unique behavioral health needs that the current system is ill prepared to meet. Other challenges include fragmentation across systems, lack of evidence-based services, and funding structures that are not supportive of individualized, family-centered care.

Specifically the State Infrastructure Grant application proposes to help expand wraparound across systems, develop service models for challenging populations (children ages birth through 5, transition-aged youth, and youth with co-occurring substance abuse and mental health disorders), establish culturally and linguistically appropriate practices, and create a forum for state agencies to work with stakeholders to develop an integrated, family-centered behavioral healthcare system for children and families. A wide array of stakeholders are committed to this project including the state agencies responsible for mental health, substance abuse, Medicaid, child welfare, juvenile justice, education, vocational rehabilitation, public health, and developmental disabilities. Local systems of care have also committed to the success of this project including the two SAMHSA system of care grantees (Nebraska Families Central and Families First and Foremost), the two Safe Schools, Healthy Students grantees in Omaha and Beatrice, and the Governor's early childhood mental health system of care initiative in central Nebraska. Other stakeholders committed to the project include two family organizations (NAMI-Nebraska and the Nebraska Federation of Families for Children's Mental Health), three state commissions (Nebraska Commission on Indian Affairs, Mexican American Commission, and the Crime Commission), other system of care communities such as Panhandle Partnership for Health and Human Services, provider organizations, faith organizations, University of Nebraska (Public Policy Center, Center for At-Risk Children's Services, Monroe-Meyer Institute) private foundations, and the Nebraska Legislature's Health and Human Services Committee. The need for infrastructure development identified in this application is wholly consistent with the priorities of Nebraska. Through the leadership of the Governor and the Legislature's Health and Human Services Committee, Nebraska enacted major legislation this

spring designed to ensure access to behavioral health services, create an appropriate array of community-based services and a continuum of care, coordinate behavioral healthcare with primary healthcare services, develop services that are research based and consumer focused, ensure consumer involvement as a priority in all aspects of service planning and delivery, and develop funding that is fully integrated and supports a plan of treatment.

GAP #2: DEVELOPMENTALLY APPROPRIATE SERVICES FOR YOUTH IN TRANSITION

UPDATE – November 2005

Focus on Prevocational/Employment: services for children with serious emotional disturbances continue to be provided through the public school system under the provision requiring transition services. The term transition services means a coordinated set of activities for a student with a disability that is designed within an outcome-oriented process, which promotes movement from school to post-school activities, including post-secondary education, vocational training, integrated employment (including supported employment),continuing and adult education, adult services, independent living, or community participation; is based upon the individual student's needs, taking into account the student's preferences and interests; and includes instruction, related services, community experiences, the development of employment and other post-school adult living objectives, and, when appropriate, acquisition of daily living skills and functional vocational evaluation. Transition services for students with disabilities may be special education, if provided as specially designed instruction, or related services, if required to assist a student with a disability to benefit from special education.

The Workforce Investment Act is the first major reform of America's Job Training System in fifteen years. It was signed into law by President Clinton on August 7th, 1998.
Key Components include:

- Streamlining Services - Programs and providers will co-locate, coordinate and integrate activities and information, creating a coherent and accessible one-Stop system for individuals and businesses.
- Empowering Individuals - Individual Training Accounts (ITA's) at qualified institutions will supplement financial aid from other sources and may pay for all the costs of training. A system of consumer reports will provide key information on the performance outcomes of training and education providers.
- Through ITA's, participants choose training based on program outcomes. To survive in the market, training providers must make accountability for performance a top priority.
- State and Local Flexibility - Significant authority is reserved for the Governor and chief local elected officials to implement an innovative and comprehensive workforce investment systems tailored to local and regional labor market needs.
- Improved Youth Programs
  Programs will be linked more closely to local labor market needs and community youth programs, with strong connections to academic and occupational learning.

"One-Stop" Centers serve as the cornerstone of the new Workforce Investment System. These Centers unify training, education and employment programs into one customer-friendly system in each community. At least one full-service center is located in each workforce investment area. Strategic Goals for Improved Youth Programs include:

- Nebraska parents, educators, businesses, and service providers work as partners in providing youth with opportunities for a lifelong learning environment to reflect the changing needs and skills of the workforce.
- School-to-Career efforts are strengthened and expanded in order to continually invest in our youth's future by coordinating partnerships between business, students, education, and communities.

Local areas take advantage of the School-to-Work network and existing partnerships in their areas. Collaborative planning with the schools and School-to-Work partnerships should include: preparation of all youth for adulthood, successful careers and lifelong learning, in addition to strengthening basic skills. School-to-Work partnerships can assist local Workforce Investment boards and youth councils in providing continuity between Workforce Development and the education system.

One-Stop Services to Youth
The chief elected official, as the local grant recipient for the youth program, is a required One-Stop partner and is subject to the requirements that apply to such partners.

In addition, connections between the youth program and the One-Stop system include those that facilitate:

1. The coordination and provision of youth activities;
2. Linkages to the job market and employers;
3. Access for eligible youth to the local youth program information and services; and (4) Other activities designed to achieve the purposes of the youth program and youth activities.

Local boards have the flexibility to offer services to area youth that are not eligible under the youth program through the One-Stop centers. However, One-Stop services for non-eligible youth must be funded by programs that are authorized to provide services to such youth. For example, basic labor exchange services under the Wagner-Peyser Act may be provided to any youth.

Additionally, Grand Island Senior High School (CNSSP), Region III Behavioral Health Services and NE Vocational Rehabilitation have been in partnership since September, 1999 to provide services to students ages 14-21 who are eligible for V.R. Services, Professional Partners and are served by GIHS. The targeted population are:

1. Students who are considered to be at risk in the community, school or workplace.
2. Students who are verified with disabilities (SPED or 504 eligible).
3. Students who are considered candidates for competitive employment.
4. Students who must exhibit a serious emotional disorder.

In addition to funding, Region B.H. III services include professional partner service, building informal supports, mental health assessment and related needs, crisis plan development & Wraparound services. Grand Island HS services include the funding contribution, Special Ed Assessment, IEP development, facilities, networking, academic/educational services and structural and systemic accommodation. VR services besides funding include vocational assessment and counseling, job placement, job seeking skills and job retention counseling and employment related independent living skills. Services provided with cooperative funding include job coaching , job specific training, required tools, clothing, on the job training, mentoring, Transportation and miscellaneous individual accommodations necessary to employment success.

For the past four (4) years, the average number of students served each year is 8. The average age of the students have been 16 and have had a variety of Behavioral Health disorders. Each student has had professional partner and wraparound services, educational accommodations. The vocational services have included job site placement and vocational counseling. Some have started in unpaid work experiences and others in regular competitive employment. This past year VR provided a weekly group focused on job keeping skills.

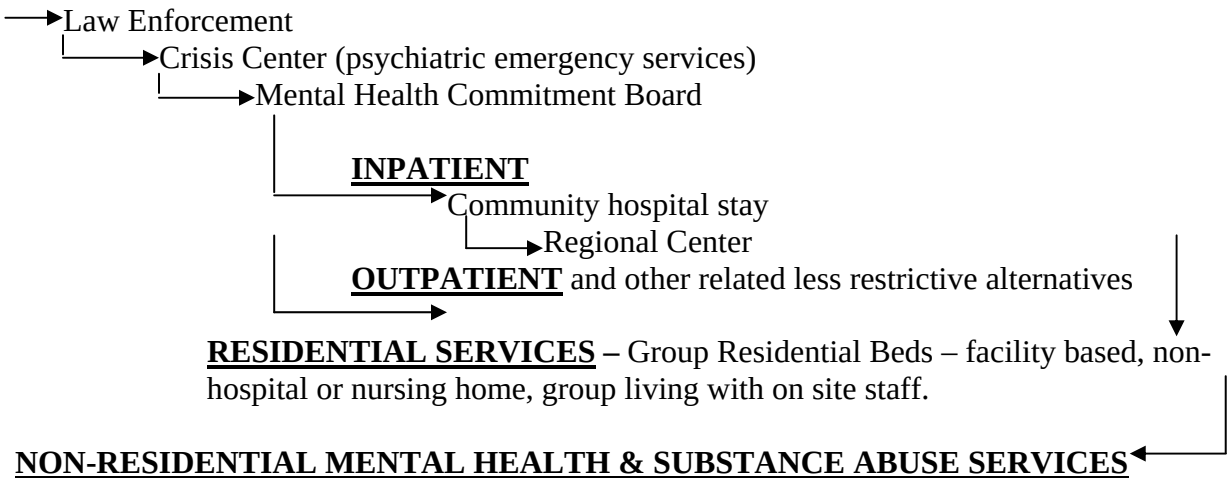
This program has been extended each year, still using the original "pot" of money. The collaboration between the agencies has kept the expenditures to only what the student needs to be successful in a job placement. The partners meet monthly to review progress on students and to process new referrals.

Another program for improving employment opportunities for youth is SCOPE. SCOPE is an acronym for STUDENT CAREER OPPORTUNITES IN PERMANENT EMPLOYMENT. This is a cooperative agreement between the Lincoln Public Schools and Voc Rehab that focuses on special education students in their last year of high school classified as either having a learning disability (SLD) or behavioral disorders (BD). These are two special education groups for which LPS has not provided employment related services to. For most of the students who participate, SCOPE places them in their first every job, provides job coaching and follow along. Approximately half of the students end up losing or quitting their job and require services again prior to or after exiting school. It is a small program as this last year it served 18 students. (for other employment, see Criteria #3).

GAP #3: LACK OF ADEQUATE "STEP DOWN" SERVICES
UPDATE – November 2005

This is looking at the "consumer flow" of adults through only the emergency psychiatric system of the Nebraska Behavioral Health System (NBHS). This flow starts with the individual going to psychiatric emergency services, into inpatient for treatment, followed by lower levels of care suitable for the consumer's needs. There are a number of problems triggering this gap. Many involve the fragmented behavioral health system in Nebraska. There are a number of different funding streams such as Medicaid, NBHS, Protection & Safety, and private health insurance. Each funding stream has its own clinical and financial eligibility requirements. The funding levels do not provide enough incentives for individuals to select mental health as a career, leading to staffing shortages (see gap #5).

MENTAL HEALTH AND SUBSTANCE ABUSE -- CONSUMER FLOW
EMERGENCY



These problems lead to a focus on public safety issues being a priority. Areas such as psychiatric emergency services are addressed. However, there are many problems here. Richard Young Center, a psychiatric inpatient facility in Omaha, closed by April 2003. The beds had been used to serve unstable or suicidal patients. The closing of Richard Young eliminated 34 percent of Omaha's inpatient mental health beds, exacerbating the current problems.

The front end of the cycle is triggered when there is not enough housing that is affordable, decent, safe, and appropriate for people who are extremely low income with serious mental illness. Housing problems for people with serious mental illness lead to increased demand for emergency psychiatric services, increased length of stay in inpatient psychiatric services, and homelessness.

LB 40 (2005) amended Neb. Rev. Stat. § 71-812 (Behavioral Health Services Fund) to authorize the use of state funds to provide Housing-related assistance for very low-income adults with serious mental illness. LB40A also provided one-time funds for for new construction, acquisition, or rehabilitation of housing to assist very low-income adults with serious mental illness. These resources should help to address the need for housing in community settings that is affordable, decent, safe, and appropriate for people who are extremely low income with serious mental illness. With this housing, an adequate supply of the lower levels of care for mental health services needs to be included.

Progress is being made to improve the mental health community based services needed in order to address this gap and reduce the demand for Regional Center services. See ADULT GOAL #1: BEHAVIORAL HEALTH IMPLEMENTATION PLAN for the development of new services. The information was reported to the Behavioral Health Oversight Commission of the Legislature (Neb. Rev. Stat. 71-818). The Nebraska Behavioral Health Reform initiatives are helping to reduce this gap.

GAP #4: INFORMATION SYSTEM IS INADEQUATE

UPDATE – November 2005

There is a continuing need to work on improving the management information systems used by the Nebraska Division of Behavioral Health Services. At minimum, there is a need to check for accuracy and provide feedback on data quality. Also, work needs to be done on reporting the data collected. NBHS, Medicaid and the Regional Centers each have their own data systems. Also, Federal Medicaid and the Federal Center for Mental Health Services have different reporting requirements. Solutions to those problems are left to the states to resolve. In general, the data needs to be used to answer questions such as "who are we serving?" "What services are they getting?" and "What results were produced?" As a result, there are various problems.

Under the Nebraska Behavioral Health Services Act, § 71-806 the duties of the Division of Behavioral Health Services are listed. The duties include (1)(e) "development and management of data and information systems". Then, as noted above, LB 551 (2005) sets legislative requirements for data and information system reporting duties for the Division of Behavioral Health Services. LB551 also requires the information to be reported to the Governor and Legislature on a quarterly basis beginning July, 2005.

HHSS continues to improve the data infrastructure to improve the capacity for data collection and reporting. For example, the AVATAR software is ready for the implementation in July 2005 at the Lincoln Regional Center. The AVATAR software is HIPAA compliant. The AIMS system will operate in parallel to AVATAR for several months following implementation. During the transitional period double entries will be done by the Regional Center staff to maintain both systems. The advantage of AVATAR is that it would provide electronic patient records and billing and reduce possible errors. The Policy Cabinet approved the implementation of the AVATAR software and the July 2005 go-live date.

Magellan Behavioral Health ASO services contract covering Nebraska Behavioral Health System (NBHS) information system was recently approved for a three year extension by the Nebraska Health and Human Services Policy Cabinet, covering FY2006, FY2007 and FY2008.

REGIONAL CENTER DISCHARGE FOLLOW-UP SERVICES

The Division has contracted with the University of Nebraska Medical Center (UNMC) Preventive and Societal Medicine. The purpose of the contract is to follow adult patients (age 18 years and older) who were discharged from regional centers starting January 1, 2005 using Nebraska Health and Human Services data. Using the data, UNMC will prepare monthly, annual, and ad hoc reports on the status of these discharged patients. The term of this Contract is from March 1, 2005 through May 31, 2006. The Objectives of the contract are

1. Develop a system to monitor the status of the patients released from regional centers. Included Regional Center Populations are adults (age 18 and older) who are served within the Regional Center Units to be downsized at Hastings and Norfolk as well as the Lincoln Regional Center Short Term Care Unit and Community Transition Program.
2. Create monthly, summary system, and ad-hoc reports based on information collected through the monitoring system.
3. Develop the reporting capacity for Federal Uniform Reporting System Tables 20 A and 20 B.

CONSUMER SURVEY DATA COLLECTION

Nebraska Department of Health and Human Services, Division of Behavioral Health Services and the Nebraska Department of Health and Human Services Regulation and Licensure, Public Health Assurance (R&L) signed an interagency agreement to collect the consumer survey data needed for the Federal Uniform Reporting System Table 11. R&L is the State Public Health Agency responsible for conducting state annual Behavioral Risk Factor Surveillance System (BRFSS) telephone survey. This survey is supported by the Centers for Disease Control (CDC).

Under the agreement, the Division of Behavioral Health Services provided the questionnaire and cover letter. The Division also provided an electronic file (in Excel) of 5,000 names, addresses, and other related information. In April 2005, the Division provided the consumer to be contacted: Dual - 17 - Children and 138 – Adults; Mental Health - 463 - Children and 2,238 – Adults; Substance Abuse - 147 Children and 2,500 – Adults; for the following totals - children - 628 and 4,872 Adults (5,500). The Division is also responsible to arrange for data analysis to be completed.

Under the agreement, R&L translated the survey materials provided into Spanish, sent a letter to the consumers receiving the survey to introduce the survey, explains the need, how the consumer will be contacted by phone at a specific number sometime over the next few weeks. The letter provides the consumer with an opportunity to indicate (a) wrong number to reach them, (b) do not call me, but send me a questionnaire or (c) do not call or send me anything (decline participation). A toll free number (1-877-791-7359) was provided to have the consumer call R&L to provide the corrected phone number, to request a mail survey, or to decline participation. If the consumer does nothing, it served as a form of consent to participate on the survey. R&L is authorized to call the listed phone number. The surveys are to be completed by September 29, 2005. The same process for this Behavioral Health survey is being used as the Nebraska Behavioral Risk Factor Surveys (BRFS) samples.

GAP #5: SHORTAGE OF CREDENTIALED & ADMINISTRATIVE STAFF
UPDATE – November 2005

There is a critical shortage of qualified Nebraska Behavioral Health Staff for providing treatment, rehabilitation and support services as well as handling administrative functions. The shortage of credential staff includes psychiatrists, psychologists, licensed mental health practitioners (LMHP), nurses and Alcohol/Drug Abuse Counselors. With all the increasing expectations on what the Nebraska Behavioral Health System (NBHS) needs to address, there also needs to be adequate supply of administrative personnel at all levels of operations.

In order to help address these issues, the University of Nebraska Medical Center, Health Professions Tracking Center (HPTC) will be completing a “Mental Health Professionals Survey”. The survey will be sent to licensed mental health professions of Psychiatrist, Psychologist, Licensed Mental Health Practitioner (LMHP), and Licensed Alcohol/Drug Abuse Counselor (LADAC). Registered Nurses will be covered in a separate survey. The survey will be asking questions on the professionals educational background, whether or not the person is actively seeing patients, the practice locations, a biosecurity assessment (training needs / training skills), and related areas.

Mental Health Professional Shortage Areas (MHPSAs) (page 39; 2003 Databook)
In 2003, the U.S. Department of Health and Human Services designated over 90 percent of Nebraska’s counties (88 of 93) as MHPSAs. Based on 2000 census data, the population within these

shortage areas (N = 1,045,809) exceeds 61 percent of the state's total population. Several other facilities serving low income and institutionalized populations are also designated.

The data below is the current supply of Nebraska Psychiatric Professionals, based on their primary practice locations, as of June 2005, according to the University of Nebraska Medical Center's Health Professions Tracking Center.

PSYCHIATRIC SHORTAGE AREAS In Nebraska, Psychiatric Professionals, Primary Practice Locations (July 2005):

Region	Psychiatry		Child / Adol. Psychiatry		Nurse Practitioners		Physician Assistants		Totals	
	#	%	#	%	#	%	#	%	#	%
1	4	3%	1	5%	2	10%	0	0%	7	4%
2	2	2%	2	10%	2	10%	0	0%	6	3%
3	10	8%	2	10%	7	35%	0	0%	19	11%
4	10	8%	1	5%	0	0%	2	40%	13	8%
5	24	19%	3	14%	7	35%	2	40%	36	21%
6	59	46%	17	81%	10	50%	3	60%	89	51%
Totals	127	100%	21	100%	20	100%	5	100%	173	100%

Health Professional Shortage Areas (page 40; 2003 Databook)

- Federally Designated Psychiatric Shortage Areas – 88 of 93 Nebraska Counties. The Omaha Metro Area / Region 6 are excluded. All other Nebraska counties are designated as "Psychiatric" shortage areas
- State Designated Psychiatric Shortage Areas – 87 of 93 Nebraska Counties with State Designated Shortage Areas - "Psychiatric" shortage areas. The six not designated were Buffalo, Dakota, Douglas, Lancaster, Sarpy, Scotts Bluff counties.

According to the Mental Health Care Professionals (page 41; 2003 Databook), there are Psychiatrists (140), Psychologists (330), Master Social Workers (610), Certified Professional Counselors (760), Licensed Mental Health Practitioners (1,795) and Certified Marriage and Family Therapists (76).

Nurse Shortage Counties - In nursing, 37 of 93 Nebraska's counties are considered to have a shortage, as of 11/04/02. The list of "Nursing Shortage County" is from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing <http://bhpr.hrsa.gov/nursing/shortage.htm#ne>.

Lack Of Expertise Available To Work With Persons With Dual Disorders

Substance abuse and dependence may go undiagnosed and untreated in adults with serious mental illness and children with serious emotional disturbance. Assessing substance abuse disorders is a key issue here.

This is especially a problem for children with serious emotional disturbance. All of the Nebraska Behavioral Health Regions throughout the state of Nebraska have expressed the need for more qualified staff and professionals, more specialized training for all non mental health staff and

professionals who work with children diagnosed with a dual disorder (mental health and substance dependence). There is a need to expand services in order to serve more youth in rural and frontier areas. Treatment professionals and educators, as well as parents in Nebraska would benefit from more education and training to assess and refer children for dual disorder treatment, and earlier intervention and assessment services. Furthermore, the need for more cooperation and communication between the mental health and substance abuse treatment systems, as well as other child serving systems.

LB1083 (2004) sections 103 – 125 amended the Uniform Licensing Law and the Requirements for Certified Alcohol/Drug Abuse Counselors (CADAC). As a result, there are now the following levels of certification: Licensed Alcohol/Drug Abuse Counselor (LADAC); Licensed Provisional Alcohol/Drug Abuse Counselor (LPADAC); and Licensed Provisional and Licensed Mental Health Professionals Special Provisions.

The following comments were made by Donald E. Fischer, MD, DABFM, C.A.S.A.M, psychiatrist and medical addictionist, in private practice, Scottsbluff, NE and former Member of the MHPEC Executive Committee (8/05/2003) He said the average physician without any special training or clinical experience may be able to diagnosis alcohol (and other) dependencies but not be prepared to recommend the level of treatment needed, depending on patient age, chronicity, prior treatment outcome, support system, and related areas. Therefore, additional training is usually needed. The same goes for a licensed psychologist without specific training in addictive and compulsive disorders. CADACs are not qualified to go beyond basic substance dependence assessment. By training and licensure they are not qualified to recognize comorbid disorders such as Bipolar disorders, ADDH, OCD and other anxiety disorders, Axis II disorders, etc. Medical conditions accompanying substance dependence are beyond their purview, as well as the role of psychoactive medications (both dependency-producing and those needed in treatment, i.e.: antidepressants).

Mental health is chronically under funded. To address the staffing issues, models of care must be adopted that allow the system to use the available expertise to the greatest extent possible. For example, general practice physicians, advanced practice nurses, and physician's assistants may be able to fill the roles of psychiatrists. In non-medical areas Licensed Mental Health Practitioners and Psychologists have filled traditional therapy roles. The use of physician extenders, non-physician program directors with psychiatric consultation, shared consumer management duties with other professions, and consultation over the internet are but a few of the ways that psychiatric expertise can be used.

Blaine Shaffer, MD (Chief Clinical Officer for the Division of Behavioral Health Services) commented on the shortage of psychiatrists in Nebraska. He said, "The point is that we need psychiatrists, not others acting as psychiatrists. One issue involved in medical students not choosing psychiatry is their perception that you don't have to be a trained psychiatrist to do psychiatry. Physician extenders are very helpful but should not replace psychiatrists. "Telepsychiatry could be a way for psychiatrists and other providers to collaborate and provide quality care for people in shortage areas. This modality is also currently underfunded."

For more information on the federal Health Professional Shortage Area status contact Thomas Rauner in the HHS Office of Rural Health and Primary Care (402-471-0148).

GAP #6: MEDICATION ACCESS
UPDATE – November 2005

This gap involves many things related to providing access to psychiatric medications for persons with serious mental illness or youth with serious emotional disturbance. Without access to medication, people with mental illness may stop taking the treatment. That leads to an increase in the likelihood of a serious episode, resulting in emergency room visits, in-patient hospitalization, and crisis services. One of the SAMHSA Evidence-Based Practices (EBP) is Medication Management. It involves the systematic use of medications as a part of the treatment for schizophrenia. For more information see <http://www.mentalhealthpractices.org/se.html>.

This is from the MHPEC Strategic Planning meeting on April 12, 2002.

- "Medication Access" is an issue because:
  - there is not a stable reliable source of medications for people with mental illness.
  - no clear cut mandate on who is to pay for what. Everyone wants to be the one who pays last dollar.
- "Medication Access" Theme: Reducing the barriers to getting the right drug to the right recipient in the right dosage by the right route at the right time to consumers in community mental health settings.

There are many groups involved in this medication access issue ranging from

1. Consumers, family members
2. County Level Services: Counties, County Attorneys, Mental Health Commitment Boards, Sheriffs (transportation), Veteran Service Center, County Corrections
3. Service Providers: Regional Centers, Community Mental Health providers, Emergency Care Centers, Housing providers; Pharmacies, Physicians, and other health care practitioners, Nebraska Medical Association's mental health task force, Regional Governing Boards, Law enforcement, Corrections ...
4. Payers: Medicaid, Medicare, Managed Care Companies, Private insurance companies, SSI, SSDI, and Nebraska Department of Health and Human Services.
5. Resources: Drug companies, Pharmacies ...
6. Advocates / allies: Nebraska Association of Behavioral Health Organizations (NABHO), National Alliance for the Mentally Ill-Nebraska (NAMI-NE), and Mental Health Associations of Nebraska.

- LB 1148 (2002) PRESCRIPTION DRUG ASSISTANCE required the Health and Human Services Committee, on or before December 1, 2002, to conduct research and provide recommendations to the Nebraska Legislature and the Governor on the topic of prescription drug assistance. The bill required the committee to consult with members of the Legislature, the Governor, the Nebraska Health and Human Services System, the Department of Insurance, the Department of Revenue, political subdivisions, area agencies on aging, pharmacists, pharmaceutical manufacturers, advocates for the elderly and persons with mental illness, health care providers, insurance companies, and other interested parties.

- Summary on Medication Support Oriented Comments from the "ACCESS TASK FORCE" Forum held on January 20, 2000 in Omaha by the Nebraska Mental Health Planning and Evaluation Council (MHPEC).

- Many times know someone needs to get into hospital, but are not yet to the crisis level of MI & Dangerous. If not eligible for Medicaid or Medicare, it is real hard to get money for the medications. If you can get the medications you can prevent the need for the hospital bed.
- substance abuse is self medication ... abuse and violence may come with it.
- access to insurance company - need 20 phone call to get care ... a barrier to services
- working poor - person is not eligible for Medicaid because they work but do not earn enough to pay for the medication. With Medicaid you can usually find someone who can take care of the individual ... the working poor need some mechanism to access the care.
- One person testified he was on 8 different medications in last 15 years.
- Trouble in rural NE not the same in urban NE … shortage of psychiatrists.

Trish Blakely, Healthy Families (August 11, 2004): "It is also a tremendous problem trying to locate a psychiatrist to prescribe medication. There seems to be a very long waiting period to see a psychiatrist. Families have little selection about whom they see due to the choices available and if there is a crisis situation there is little probability that they will be able to reach a psychiatrist to get assistance. This happens over and over with families in Healthy Families Project and the Family Resource Center."

Nebraska is paying for medications. Here are examples:

- One source to pay for psychiatric medications is "LB95". This is an indigent outpatient, prescription medicine program administered by the Department of Health and Human Services. It is authorized under Neb. Rev. Stat. §83-380.01 (Laws 1981, LB 95, § 25). The authorized consumer is indigent, receiving outpatient medications, and has a history of Board of Mental Health commitment to inpatient or outpatient levels of care. In FY2003 the Nebraska Office of Mental Health, Substance Abuse And Addiction Services", paid $600,000 for "Indigent Medications". The Community Mental Health Funding via the Division of Behavioral Health Services line item "Indigent Medications" (through Regional Centers) was $2,000,000 in FY2004. 752 Consumers have received medication from Nebraska Regional Centers (as of December 21, 2004.)
- The administrator for the Division of Behavioral Health Services held a meeting on March 11th, 2005 to discuss the intricacies, issues, and process for accessing medication through LB95 funds and the pharmacies at the Regional Centers. The meeting began the process for improving the utilization of medication funds in Nebraska. Information from this meeting has been utilized to write draft regulations for the *Provision of Prescription Medicine Necessary for Mental Health Treatment to Indigent Person Receiving Outpatient Services who has Received MHB Ordered Treatment* and will involve the creation of a workgroup to manage utilization of LB95 services. The LB95 utilization group will look at the possibility of a common formulary for LB95 medications; distribution of medications through local pharmacies, such as Walgreens; and identifying a mechanism for utilization of newer medications.
- Nebraska belongs to the Minnesota Multi-State Contracting Alliance for Pharmacy which is a purchasing organization that allows the State to acquire medications at a reduced rate.
- The National Association of State Mental Health Program Directors collects "Mental Health Expenditures and Revenues report" annually. For 2003, Nebraska reported total expenditures for psychiatric medications as $72,923,396.

FY 2003 Expenditures for Psychiatric Medications and "Atypical" Antipsychotics

	State Psych Hospitals	Medicaid	LB95	Total

Atypical Antipsychotics	NA	$28,348,305	NA	$28,348,305
All Other Medications	NA	$40,075,902	NA	$40,075,902
Both	$3,899,189		$600,000	
TOTAL PHARMACY	$3,899,189	$68,424,207	$600,000	$72,923,396

NA = Services provided but exact expenditures not available.
To the nearest $100,000 / Prepared December 2004

GAP #7: CULTURALLY COMPETENT SERVICES
UPDATE – November 2005

In 2004 a critical service gap in the adult and children's mental health system was identified to be cultural and linguistically competent services. A language barrier was reported in several communities across Nebraska both rural and urban, due to the increase in minority populations living across the state. In 2005 these barriers continue to be a problem as the service gaps have not been addressed.

This gap in mental health care was first identified nationally in 1999 by the Surgeon General who addressed disparity as lying in the availability, accessibility, and quality of mental health services for racial and ethnic minorities. The Surgeon General made it clear that these disparities result in ethnic and racial minorities bearing a disproportionately high disability burden from mental disorders. The Surgeon General also identified the lack of information regarding the mental health needs of many racial and ethnic minorities as adding to the critical disparity. As part of the challenge to the nation the Surgeon General released *Healthy People 2010* in early 2000 to address disparities in health care access and outcome.

In December 2000, the Office of Minority Health, U.S. Department of Health and Human Services, published final recommendations on national standards for culturally and linguistically appropriate services in health care. These are meant to be a blueprint for federal and state health agencies, policy makers, and national organizations to build culturally competent health care organizations and workers.

Sadly, Nebraska continues to lag behind in implementation of the Cultural and Linguistic Appropriate Services (CLAS) which could facilitate the closing of this gap. On February 8, 2005 the State Advisory Committee on Mental Health Services first addressed cultural competence goals and objectives. Dr. Maria Prendes-Lintel presented on the fourteen Cultural and Linguistic Appropriate Services (CLAS). These CLAS were identified and members of the committee were asked whether their agencies were in compliance with these standards particularly those that are federally mandated. The lack of resources and complexity in addressing these gaps was discussed as well as the cost and complexity of not addressing these needs. The importance of having competent and trained interpreters was highlighted. The impact of the language barrier was addressed as one of the most critical gaps affecting access, delivery and viable use of mental health services. One way this disparity can begin to be addressed in Nebraska is for the Behavioral Health Council that oversees the Mental Health, Gamblers and Substance Abuse committees to develop a subcommittee to address the cultural competency of those providing services. It is a goal in the future to close this gap and report progress in this area.

Tanya D. Cook, Governor's Director of Urban Affairs and Manager, Office of Minority Health noted a need to work with Sudanese and Somali Bantu refugees. They have unique mental health

challenges due to conflicts in their home countries and refugee camps; how issues are handled within family structure and less likely to seek outside help.

Jackie Miller, HHS Deputy Director Health Services noted the following, “Domestic violence is the norm in Sudanese households. In addition the women are not allowed to speak when interviewed, etc----the men speak for the women. For those women who do break away and get help, the family unit is completely destroyed. The father looses the respect of his children----as he is unable to keep his wife under thumb (especially if she ends up in a shelter). The children also despise the mother in such cases.”

Jose J. Soto said, "Despite the rapid growth of the Hispanic/Latino population in our rural communities, public sector response to the mental and behavior health service needs of that population have been slow to come and not commensurate with the growth, verified needs and often dire circumstances of this population. Included in the latter are the harsh realities of chronic poverty, the lack of adequate and stable medical care, cultural isolation, racism, and quite frequently language barriers that make available services effectively inaccessible."

It should be noted that the Division of Behavioral Health funds mental health services for the four federally recognized tribes of Nebraska (Ponca, Winnebago, Omaha, & Santee). The FY2006 contracts with the four tribes totals $503,928 for mental health services. The data presented below uses the Nebraska Implementation Report 2004 for the Federal Uniform Reporting System.

Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	White	More Than One Race Reported	Race Not Available	Total
Total	536	68	807	10	14,732	1,284	959	18,396
% of total	2.9%	0.4%	4.4%	0.1%	80.1%	7.0%	5.2%	100.0%

Race / Nebraska 2000 State Census Profile

	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	White	More Than One Race Reported	Race Not Available	Total
Total population	22,204	26,809	75,833	1,733	1,554,164	55,996		1,736,739
% of Total	1.3%	1.5%	4.4%	0.1%	89.5%	3.2%		100.0%

The data presented below uses the Nebraska Implementation Report 2004 for the Federal Uniform Reporting System.

Table 2B. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

	Not Hispanic or Latino	Hispanic or Latino	Hispanic or Latino Origin Not Available	total
Total	16,516	938	942	18,396

% of total	89.8%	5.1%	5.1%	100.0%
Total Nebraska population		1,711,263	100%	
Total Hispanic or Latino (of any race)		94,425	5.5%	

The race and ethnicity data are as reported on Nebraska 2000 State Census Profile, Nebraska Department of Economic Development web site. http://info.neded.org/neprof00.htm

GAP #8: ELDERLY POPULATION NOT BEING SERVED
UPDATE – November 2005

Another important gap is mental health services to elders. In the Report of the Surgeon General on Mental Health, it notes that millions of older Americans—indeed, the majority—cope constructively with the physical limitations, cognitive changes, and various losses, such as bereavement, that frequently are associated with late life. However, a substantial proportion of the population 55 and older—almost 20 percent of this age group—experience specific mental disorders that are not part of "normal" aging. Research has helped differentiate mental disorders from "normal" aging. This includes depression, Alzheimer's disease, alcohol and drug misuse and abuse, anxiety, late-life schizophrenia, and other conditions can be severely impairing, even fatal. In the United States, the rate of suicide, which is frequently a consequence of depression, is highest among older adults relative to all other age groups.

The data presented below uses the Nebraska Implementation Report 2004 for the Federal Uniform Reporting System. Table 2A shows a total number of persons served as 18,396. That means those served age 65+ represents 2.9% of the total. Table 14A shows a total number of persons served as 7,089. That means those served age 65+ represents 3.5% of the total.

Nebraska Persons Served

	Table 2A Total	Table 14A Total
65-74 years	342	176
75+ years	195	71
Total 65+	537	247

Table 2A shows 537 people age 65+ (2.9%) out of the total persons served of 18,396. Table 2A is the "Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity". The data is an unduplicated count of all institutional and community services using Magellan Behavioral Health (MH, SA, Dual) and AIMS (Regional Centers) for state fiscal year (July 1, 2003 to June 30, 2004). The services are provided or funded by the state mental health agency (HHS Division of Behavioral Health Services). Table 14A is a profile of Persons with SMI/SED served by Age, Gender and Race/Ethnicity. It is the same data as Table 2A, sorted by Axis I Diagnosis 295 to 298.9 AND Axis V less than 60 (GAF SCORE). Meanwhile, the Nebraska Census Data shows (2000) shows the number of people over age 65.

Nebraska Census Data shows (2000)

65 to 74 years	115,699	6.8
75 to 84 years	82,543	4.8
85 years and over	33,953	2

The State of Nebraska population total age 65+ is 232,195, which is 13.6% of the total population of 1,711,263. While overall, 18.4 percent of the state's population is comprised of people 60 and older, some counties in Nebraska have much higher rates of older citizens. The counties with the highest over 60 population are Pawnee (35 percent), Webster (33 percent), Franklin (33 percent), Furnas (33 percent), Thayer (32 percent) and Hooker (32 percent).

SECTION THREE: FY2005 GOALS

FOR ADULTS
ADULT GOAL #1: BEHAVIORAL HEALTH IMPLEMENTATION PLAN ACHIEVED

This goal is to successfully implement the Nebraska's Behavioral Health Reform. Below represents a summary of key points to illustrate the work being completed under Adult Goal #1:

State Priorities: The plans and funds appropriated to the behavioral health (mental health and substance abuse) system are specifically intended to serve the adult population. On July 1, 2004, the Nebraska Health and Human Services System released the Behavioral Health Implementation Plan. The complete 208-page Behavioral Health Implementation Plan and other information regarding implementation of LB 1083 (2004) can be accessed at the HHSS website at http://www.hhs.state.ne.us/beh/reform/.

The following information is to demonstrate the direction the community component of the Nebraska Behavioral Health Reform is taking. For FY2006, the goal is to continue moving in this direction. Below is a progress report on the Development of Community-based Services in the six Regional Behavioral Health Authorities as presented on August 12, 2005 to the Behavioral Health Oversight Commission of the Legislature.

The plans and funds appropriated to the behavioral health (mental health and substance abuse) system are specifically intended to serve the adult population and to directly impact the following state priorities:

Phase I: Regional Center REPLACEMENT Services.

Priority A – **REPLACEMENT** services to replace current HRC/NRC acute inpatient and secure subacute residential services

Priority B – **DISCHARGE READY** services for persons currently being served in the HRC/NRC/LRC

Priority C – **EMERGENCY SERVICE** development and/or restructuring to reduce EPCs and commitments in the regions.

Phase II: Expansion of Community Based Services to Impact Reduction in Need for Acute and Secure services.

Priority A: **NON-RESIDENTIAL SERVICE** development and/or expansion to reduce use of acute inpatient and secure subacute residential services, and increase community tenure in the least restrictive setting with stable housing.

Region I Reform Plan New Services (as of 8/5/2005)

- Acute & Subacute Inpatient, Scottsbluff (Operational); Provider: Rg West Medical Center
- Crisis Response Team with ECS, Scottsbluff, Banner, Morrill Counties (Target Date 9/1/05) Provider: Region 1
- Crisis Respite, Scottsbluff (Operational); Provider: Region 1
- Dual Disorder Residential (2.5 beds), (Target Date 9/1/05); Provider Regional West Medical Center;
- Short Term Res. (1 bed) (Operational); Providers: NEPSAC, Humans Services Inc., Seekers of Serenity; 3 providers allows flexibility to serve persons quickly based on bed availability
- Medication Management, Regionwide (Operational); Provider Region 1
- Community Support, Chadron (Operational); Provider: Western Community Health Resources

Region II - Reform Plan New Services (as of 8/5/05)

- Crisis Respite, North Platte (Operational); Provider Liberty House
- Acute & Subacute Inpatient / North Platte, Kearney, (Operational); Providers Great Plains Medical Center and Richard Young
- Crisis Response Teams & Emergency Community Support North Platte (Operational); Provider Richard Young;
- Short Term Res. (3 beds) (Operational); Providers Touchstone, St. Monica's
- Dual Disorder Residential (2 beds) (Operational); Provider Centerpointe
- Community Support MH (40 slots), SA (20 slots), Region-wide (Operational); Providers Goodwill Industries and Region 2 Human Services
- Medication Management (60 clients), Region-wide (Operational); Provider Region 2
- Day Rehab, Region Wide (Operational); Provider Region 2 Human Services

Region III Reform Plan New Services (as of 8/5/05)

- Community Support SA(25 slots), (Operational); Provider: South Central BH Services
- Acute & Subacute Inpatient, Hastings, Kearney (Operational); Providers: Richard Young Hospital and Mary Lanning Hospital
- Short Term Res, 1 bed, Grand Island (Operational)
- Telemedicine (operational); providers MPC, Goodwill Greater NE, South Central Behavioral Services, Mary Lanning Memorial Hospital, Richard Young Hospital, Region 3 BH.
- Short Term Residential, (operational); Columbus
- Dual Disorder Residential (4 beds), (Target Date: 9/1/05); Catholic Charities, Columbus*
- Crisis Response Team, (Operational); Grand Island, Kearney, Hastings, Custer County.
- Psych Res Rehab, 1 bed, Hasting (Operational); Provider: South Central Behavioral Services
- Community Support MH (60 slots) (Operational); Provider: Goodwill Industries Greater NE
- Medication Management (548 clients), (Operational); Provider Rich Young, Mary Lanning
- Crisis Stabilization Center, Grand Island; Provider: MP; Crisis Stabilization- Target Date 11/1/05; Psych Respite- Target Date 11/1/05; Medical Detox- Target Date 11/1/05; Urgent Outpatient- Operational; Emergency Community Support- Operational; Crisis Response- Operational; Crisis Med Mgmt. Operational; Drop In Center- Operational.
- Psych Respite, Kearney (Target Date: 9/1/05); Provider Richard Young
- Day Rehab, Kearney (Operational); Provider: South Central Behavioral Services
- Halfway House, Kearney (Operational); Provider: South Central Behavioral Health Services

*** NOTE**: Dual Disorder Residential, Provider: Catholic Charities, 8 beds - Region 3 (4 beds) and Region 4 (4 beds) located in Central Nebraska

Region IV Reform Plan New Services (as of 8/5/05)

- Crisis Stabilization Center, (Target Date: 12/1/05); Provider: Catholic Charities, Columbus
- Psych Res Rehab (8 beds), (Target Date: 9/15/05); Provider: Catholic Charities, Columbus, In process of signing lease & remodeling
- Crisis Respite, (Operational); Provider: R Way, Liberty Center, Rainbow Center
- Crisis Response Team, (Operational); Provider: Norfolk
- Emergency Community Support (Operational); Provider: Heartland Counseling Services, Inc, So. Sioux City
- Community Support MH/SA, Region wide (Operational); Provider: Catholic Charities & Liberty Center (60 slots); SA Catholic Charities(25 slots)
- Medication Management- (Operational); Provider: Faith Regional (150 clients)
- Acute & Subacute Inpatient, (Target Date: 9/1/05); Provider: Faith Regional, Norfolk. Hospital attorneys reviewing contract language.
- Dual Disorder Residential (4 beds), (Target Date: 9/1/05); Catholic Charities, Columbus*
- Day Rehabilitation Norfolk, Columbus and Wayne, (Operational); Providers: R way, Libery Centre, and Rainbow Center
- Psych Res Rehab, Columbus (Target Date: 9/01/05); Provider: Catholic Charities

Region V Reform Plan New Services (as of 8/5/05)

- ACT, Lincoln (Operational); Providers: The Community Mental Health Center (CMHC) of Lancaster County, Lutheran Family Services, and CenterPointe
- Community Support, MH (Operational); Provider: CMHC of Lancaster County
- Community Support, SA (25 slots) (Target Date: 9-1-05); Provider: Center Pointe
- Short Term Res.(4 beds) (Operational); Provider: Cornhusker Place, Touchstone
- Therapeutic Community,(2 beds) (Operational); Provider: St. Monica's
- Dual Residential, (2 beds) (Operational); Provider: Center Pointe
- Emergency Community Support (Operational); Providers: Blue Valley Mental Health Center, Lutheran Family Services, and Houses of Hope
- Crisis Response Teams, (Target Date:9/1/05); Providers: Blue Valley Mental Health Center, Lutheran Family Services, and Houses of Hope

Region VI Reform Plan New Services (as of 8/5/05)

- Crisis Response Teams, Cass, Dodge, Washington, Sarpy and Douglas Counties (Target Date: None); Provider: None.
- Emergency Community Support (Operational); Provider Salvation Army
- Phase I Psych Res Rehab, (12 beds) Omaha (Operational); Provider: Community Alliance
- Phase II Psych Res Rehab (8 beds) (Operational); Provider: Community Alliance
- ACT (#2), Omaha (Operational); Provider: Community Alliance
- Medication Management (3939 units),Omaha (Operational); Providers: Lutheran Family Services and Catholic Charities
- Day Rehab (47 slots), Omaha (Operational); Provider: Community Alliance
- Community Support MH (120 slots), (Operational); Providers - Catholic Charities, Friendship Program, and Lutheran Family Services

- Phase I Dual Disorder Res (8 beds), Omaha (Operational); Provider: Catholic Charities
- Phase II Dual Disorder Res (8 beds) Omaha, (Operational); Provider: Catholic Charities
- Subacute Inpatient, Omaha (Target date: 8/29/2005); Provider: telecare, Inc.)

Special note on Region 6 and the Community Resource Center (CRC)

- Region 6, the Division of Behavioral Health Services, community providers, and numerous leaders have been meeting to develop ideas relating to a Community Resource Center. The concept for the Community Resource Center is to provide a central location for psychiatric crisis and triage across a continuum of care that will ease the burden on strained emergency rooms and law enforcement in Region 6. The CRC would be open 24 hours per day, 7 days per week; able to serve individuals who are voluntary or involuntary, mentally ill, substance abuse and/or co-occurring, and are of age 19 and older. Appropriate movement between levels of care is designed to take place in a timely manner.
- The Community Resource Center may include some of the following services: Crisis Phone Line, Assessment, Minor Medical, EPC, Crisis Stabilization, Crisis Response Teams and Emergency Community Support. In addition, discussions have included how the universities might be able to use the center to provide education and research opportunities for mental health professionals and students in health care professions. It will also provide a base for consultations over a "telehealth" network expected to link sites across the state.

HOUSING-RELATED ASSISTANCE - As noted above, LB 40 (2005) amended Neb. Rev. Stat. § 71-812 (Behavioral Health Services Fund) to authorize the use of state funds to provide Housing-related assistance for very low-income adults with serious mental illness. All six Regions have signed contracts and are in the process of program development & implementation.

Regional Center Census –June 30, 2005 / Excludes: Adolescent, Forensic & Sex Offender Units

Regional Center	Unit	Census
Hastings Regional Center	Residential Rehab	38
Lincoln Regional Center	Short Term Care	40
	Community Transition	38
Norfolk Regional Center	Geriatric Medical – 1W	33
	SPMI, Male – 2E	37
	SPMI, Mixed – 3E	37
	Transition / Rehabilitation – 2W	36
	Admissions – 3W	36
TOTALS Three Regional Centers as of June 30, 2005		295

This table shows the census on the units in the three Regional Centers subject to the Behavioral Health Reform, as of June 30, 2005.

ADULT GOAL #2: EMPOWER CONSUMERS
ACHIEVED

Office of Consumer Affairs.

§71-805 Neb. Rev. Stat. establishes an office of consumer affairs in the Division of Behavioral Health. A nationwide search was conducted in late 2004 and early 2005. A candidate was tentatively identified to be the Administrator of the office, but it did not work out. It is anticipated the new Administrator of the office of Consumer Affairs will be hired by the end of 2005 by the Director of Health and Human Services with consultation with the new Administrator of the Division of Behavioral Health.

Consumer Liaisons

The Division of Behavioral Health Services has employed two consumers for over 13 years. Initially, these consumers were part time employees. In 1998, they were converted to full-time employees. The two full-time Consumer Liaisons on staff are Dan Powers and Phyllis McCaul. Overall, the consumer liaisons continue working as change agents and advocates as staff members within the Nebraska Department of Health and Human Services. Their leadership both within the Division of Behavioral Health Services and in community settings changes the dynamics of a meeting, with consumer concerns being addressed more consistently. Thus, in effect, this has operated as an Office of Consumer Affairs.

FUNDING: The Division of Behavioral Health Services allocates $104,308 for State Administration (5%) from the Community Mental Health Services Block Grant ($2,086,159 for FY2006) annually on consumer empowerment oriented activities. This includes funding two full-time Consumer Program Specialist (known as Consumer Liaisons) on staff as well as the Annual Consumer Conference (for about 100 mental health consumers). Annually the HHS funds a consumer conference designed to educate consumers in mental health issues and to speak up to national, state and local mental health officials to advocate on their and the systems behalf.

Funded Consumer Activities in FY 2006

State Consumer Initiatives Contracts	
National Alliance for the Mentally Ill –Nebraska - The Office contracts with the National Alliance for the Mentally Ill -Nebraska to ensure a state organizational structure is available for consumers. It will also conduct consumer sensitivity training for administrative and front line staff of mental health and substance abuse providers.	$46,445
League of Human Dignity - This contract is used to fund cash advances and reimbursements to consumers in order to help people attend meetings, workgroups and conferences.	$10,000
Mental Health Association of Nebraska - The Office contracts with the Mental Health Association to ensure a state organizational structure is available for consumers and provide consumer sensitivity training to administrative and front line staff in Nebraska nursing homes and assisted living facilities	$46,445
Partners in Recovery – for substance abuse consumers	$43,245
Each region gets $5,000 for Family Organizations – The Office partners with HHS Protection and Safety to fund family organizations to provide family mentoring services to families of SED Children. A Family Organization is funded in each region. The Office provides $5,000 per Region. +	$30,000
Peer Specialists - Goes to the Regions to pay for employees in Day Support who are peer specialists. These are Federal MH Services Block Grant aid funds in addition to the administrative set aside	$60,000
Federal MH Services Block Grant 5% administrative set aside to fund two Consumer Liaisons & Annual Consumer Conference	$104,308

WEB SITE: The Nebraska Department of Health and Human Services web site provides a summary on how to contact the Consumer Liaisons. Mental Health Consumer Advocacy <http://www.hhs.state.ne.us/beh/mh/mhadvo.htm>

AREAS OF WORK

This is a brief list of the areas the two Consumer Liaisons address:

- Mental Health Consumer Advocacy
- Annual Consumer Conference
- Advisors on HHS Community Mental Health Policy
- Promote the development of Peer Specialists
- State Advisory Committee on Mental Health Services Dan Powers is the Professional Staff to this committee from the Division
- Advisory Panel for the Health Systems Research Evaluation of the SAMSHA/CMHS Mental Health Block Grant Program." William Ford, Ph.D. a staff member of HSR is managing the first ever evaluation of the Mental Health Block Grant. Dr. Ford is a former Nebraskan and former Deputy Director of the Department of Public Institutions. Dan Powers is one of five members on the first evaluation of the Mental Health Block Grant. Mr. Powers is the Self-Identified Adult Mental Health Consumer on the Committee.
- Projects for Assistance in Transition from Homelessness (PATH) Dan Powers is the State PATH contact.
- National Association of Consumer/Survivor Mental Health Administrators. Dan Powers presented a resolution to the NAC/SMHA Board which supports the establishment of a national memorial for consumers who have been placed in unmarked or numbered graves. NAC/SMHA passed the resolution. Mr. Powers then presented the resolution to the National Association of State Mental Health Program Directors Board. The NASMHPD Board supported the resolution. Mr. Powers is the interim chair for the project. It is anticipated it will take 10 to 15 years to accomplish.
- National Mental Health Association Dan Powers is on the National Mental Health Association Nomination Committee and will be participating on two committees of the National Mental Health Association at Quarterly Meetings in Washington, DC area.
- Alegent Health . Dan Powers participated in the Alegent Health Decision Accelerator for planning for Mental Health and Substance Abuse Services .
- Co-Coordinate the annual Board of Mental Health Training
- Consumer Representative of Midwest Regional User Group sponsored by the Federal Center for Mental Health Services to address data infrastructure issues. Phyllis McCaul is the only consumer representative.
- Expansion of Site Visits (to 44 in a 24-month period) to review Substance Abuse Programs for Consumer Involvement and Outcomes. Phyllis McCaul conducts site reviews
- Continue Consumer Satisfaction Program Visits (totaling 52 in a 24-month period), including updated satisfaction survey. Phyllis McCaul conducts site reviews.
- Host 1-800 Phone Line and provide information regarding Mental Health and Substance Abuse Services.
- Consumer Mailing List developed and maintained
- Participate in SIG HHS Internal Stakeholders Committee meeting for Children's Mental Health Services. Phyllis McCaul is the only consumer representative on this committee.
- Child Services Initiative. Phyllis McCaul is consumer representative on this initiative.

- Mentor between 2 and 6 Nebraska Consumers at one or more National Mental Health Conferences each Year.

ADULT GOAL #3: SUICIDE PREVENTION INITIATIVE
ACHIEVED

The Nebraska Statewide Suicide Prevention Initiative Committee continues to meet regularly to update and revise goals and objectives for Nebraska's suicide prevention plan. No additional funding has been specifically budgeted or accessed for suicide prevention planning or support of state activities. The State Advisory Committee on Mental Health Services recommended, relative to the 2004 MH Block Grant Application, that the State seek federal funding. In response to this advice, Nebraska Health and Human Service System and the Nebraska State Suicide Prevention Committee submitted an application, on June 1, 2005, for State Sponsored Youth Suicide Prevention and Early Intervention Program. A response is anticipated in September of 2005.

The Southeast Nebraska Suicide Prevention Curricula continues to be disseminated. The core curriculum was presented by mental health consumers at the Nebraska Alliance for the Mentally Ill State Conference in 2004. It has been available for download through the University of Nebraska Public Policy Center's faith initiative, NEBHANDS, web site (http://www.nebhands.nebraska.edu/Resources.htm#Suicide). It was also distributed to Nebraska faith based and community organizations via hard copy and cd-rom through Interchurch Ministries of Nebraska. Additionally, the curriculum was distributed to a national audience at the 2004 Christian Unity Conference in Omaha, Nebraska. The curriculum was sent to Dr. David Litts of the SPRC in 2004 for use a model of public domain educational material that can be rapidly and widely disseminated and used by different groups. The clergy module of the Southeast Nebraska Suicide Prevention Curriculum contained eulogy recommendations that were piloted for the SPRC. The Law Enforcement Module has been fully integrated with the Nebraska Law Enforcement Training Academy and is now a standard part of the training that Law Enforcement recruits receive in the state of Nebraska. This year the Law Enforcement Module was presented to veteran officers in Northeast Nebraska as part of a NEBHANDS funded collaborative project. The health care module has been translated into video format for easy viewing by health care personnel and is a standard part of the yearly training required by at least one of the major hospitals in Nebraska (BryanLGH Medical Center). It is also regularly presented to hospitals that are part of the Heartland Health Alliance across Nebraska.

The state committee participated in the development of Nebraska's injury prevention planning in the area of suicide prevention in 2005. The committee will have a regular presence in 2006 with the health department advisory group that includes planning for intentional self harm and youth prevention efforts.

On October 1, 2004, the Suicide Prevention Resource Center (SPRC) launched a new web service as part of its ongoing commitment to help states build capacity to implement and evaluate suicide prevention programs. This site links to the 2005 – 2006 Nebraska State Suicide Prevention Plan and a Nebraska suicide data fact sheet.

What's next? NE Health and Human Service System and the NE State Suicide Prevention Committee intends to promote mental health awareness, well-being, and the prevention of youth suicide by enhancing and expanding youth suicide prevention social awareness efforts; training and

education; and coordination of care among health care providers and community organizations. Pending funding provided by the State-Sponsored Youth Suicide Prevention and Early Intervention grant, the Nebraska Youth Suicide Prevention Project goals are to:

1. Create an infrastructure and workplan for implementation of the Nebraska Youth Suicide Prevention Project.
2. Expand Project Relate, existing suicide prevention social marketing efforts in the state, to focus on youth suicide prevention.
3. Promote continued and expanded use of the Suicide Prevention Curriculum developed by the Nebraska State Suicide Prevention Committee.
4. Provide community-wide crisis management training and support for schools, law enforcement, faith-based communities, and other community and family support organizations dealing with a loss as a result of suicide.
5. Create a referral network of Primary Care Physicians and Mental Health Services Providers to immediately assist at risk youth and their families and to provide continuity of care.
6. Partner with juvenile correctional, detention, and out of home placement agencies across the region to adopt and utilize the Greenline Suicide Prevention Program to train facility staff on youth suicide prevention.
7. Partner with the School Community Intervention Program (SCIP) at the Lincoln Medical Education Partnership to increase the number of schools participating in the SCIP. Program and to increase the number of providers offering free SCIP Screenings to youth.
8. Enhance the ability of hotlines to appropriately assess and intervene with youth who are suicidal or depressed.

The proposed pilot project service area is Behavioral Health Region V, which encompasses a 16 rural and urban county area in southeast Nebraska. The total population of the Region V is 413,557 or 24 percent of the state's population. Almost 40 percent of the region's population resides in the service area's 15 rural counties.

Project outcomes will include increased social awareness on youth suicide intervention and prevention; consistency in community response to prevent and address youth suicides; improved communication between Primary Care Physicians and Mental Health Providers; improved treatment and continuity of care; a reduction in the number of youth suicides in Region V; and the expansion of the project into the State's other Behavioral Health Regions.

While the focus of the project is on youth, achievement of the project goals will simultaneously promote structures to prevent suicide in the adult population.

FY2005 GOALS FOR CHILDREN OR ADOLESCENTS

GOAL #1: STRATEGIC PLANNING
ACHIEVED

The State Infrastructure Grant application proposes to help expand wraparound across systems, develop service models for challenging populations (children ages birth through 5, transition-aged youth, and youth with co-occurring substance abuse and mental health disorders), establish culturally and linguistically appropriate practices, and create a forum for state agencies to work with stakeholders to develop an integrated, family-centered behavioral healthcare system for children and families. A wide array of stakeholders are committed to this project including the state agencies

responsible for mental health, substance abuse, Medicaid, child welfare, juvenile justice, education, vocational rehabilitation, public health, and developmental disabilities. Local systems of care have also committed to the success of this project including the two SAMHSA system of care grantees (Nebraska Families Central and Families First and Foremost), the two Safe Schools, Healthy Students grantees in Omaha and Beatrice, and the Governor's early childhood mental health system of care initiative in central Nebraska. Other stakeholders committed to the project include two family organizations (NAMI-Nebraska and the Nebraska Federation of Families for Children's Mental Health), three state commissions (Nebraska Commission on Indian Affairs, Mexican American Commission, and the Crime Commission), other system of care communities such as Panhandle Partnership for Health and Human Services, provider organizations, faith organizations, University of Nebraska (Public Policy Center, Center for At-Risk Children's Services, Monroe-Meyer Institute) private foundations, and the Nebraska Legislature's Health and Human Services Committee. The need for infrastructure development identified in this application is wholly consistent with the priorities of Nebraska. Through the leadership of the Governor and the Legislature's Health and Human Services Committee, Nebraska enacted major legislation this spring designed to ensure access to behavioral health services, create an appropriate array of community-based services and a continuum of care, coordinate behavioral healthcare with primary healthcare services, develop services that are research based and consumer focused, ensure consumer involvement as a priority in all aspects of service planning and delivery, and develop funding that is fully integrated and supports a plan of treatment.

For younger children, Nebraska Health and Human Services has submitted an application to the U.S. Maternal and Child Health Bureau for the **State Maternal and Child Health Early Childhood Comprehensive Systems Grant Program**. Nebraska state agencies, in partnership with professional organizations, community-based providers, families, and advocates, have made significant progress in addressing various aspects of early childhood systems of care. Several initiatives have resulted in planning documents and pilot projects. A major challenge that remains is to achieve an integrated, comprehensive plan that addresses the five key components of: (1) access to health care and a medical home; (2) **mental health and socio-emotional development**; (3) early care and education/child care; (4) parent education; and (5) family support. In addition, a number of other challenges are being faced in Nebraska that impact upon the health and well-being of Nebraska's young children and their families and the system that supports early childhood programs and services. Among these are an increasingly diverse populations and large expanses of rural and sparsely populated areas. In addition, gaps exist in data availability and utilization, including an absence of agreed-upon early childhood indicators.

The goal for this proposed project is to achieve optimum outcomes for Nebraska's young children and their families through comprehensive system planning and collaborative effort among stakeholders. The proposed 2-year planning project will focus on processes and products that will be essential for laying the foundation for effective implementation of a strategic plan and the ultimate realization of improved outcomes for young children and their families. Objectives include:

1. Establish a planning structure and process that engages the full spectrum of early childhood stakeholders, with an emphasis on family involvement;
2. Develop vision and mission statements and identify key outcomes for young children and the early childhood system in each of the five essential components;
3. Develop a set of indicators linked to outcomes;
4. Identify and rank priority needs and issues in each of the five essential components;

5. Develop strategies and associated action plans for each of the priority needs and issues;
6. Obtain commitments to accept and implement the strategic plan from key policy makers; and
7. Develop a comprehensive plan for sustaining the effort.

A participatory planning process, using a comprehensive planning model, has been selected as the methodology. This model meets the criteria of bringing together various and diverse organizations and individuals to create consensus and make prudent decisions about the future of early childhood comprehensive systems. This model is based on six basic steps: (1) issue identification/orientation, (2) exploration/investigation, (4) defining the planning of task or goal setting, (4) policy formation, (5) programming, and (6) evaluation. A consultant will guide participants in the process, and provide technical assistance to build stakeholder capacity to carry out the plan and continue planning efforts in the future. A full-time project coordinator will work with an Advisory Committee, a Project Leadership Team, and eight Work Groups.

The Governor-appointed Early Childhood Interagency Coordinating Council (ECICC) will serve as the Project Advisory Committee. The ECICC has done extensive work in examining early childhood care and education issues, and its membership represents a wide range of interests, including child care providers, state agencies, parents, business, health care providers, and others. In addition, a 20 – 30 member Project Leadership Team will engage representatives of state agencies, Tribal government, provider and family associations, advocacy groups, the business community, military installations, and other important stakeholders. Eight work groups will further facilitate involvement and coordination with state-level and community-based efforts. Planning activities will actively build on earlier and existing initiatives.

The project measures progress in achieving seven planning phase outcomes and five short-term implementation outcomes. The planning phase outcomes are: (1) linkages formed among system and community/client stakeholders; (2) planning structure and staff established and functional; (3) workgroups formed, oriented to process, and prepared to carry out assignments; (4) community/stakeholder vision and mission developed; (5) strategies consistent with vision and mission; (6) policy changes identified to drive implementation phase; and (7) public support for change enhanced. The five short-term implementation outcomes are: (1) a model for shared decision making disseminated system wide; (2) improved capacity among stakeholders in the area of policy development; (3) information and administration infrastructure in place to increase exchanges; (4) system improvement resulting from training and coaching of stakeholders; and (5) ongoing stakeholder participation and data to improve early childhood systems planning.

The goal of this project is to achieve optimum outcomes for Nebraska's young children and their families through comprehensive system planning and collaborative effort among stakeholders. The proposed 2-year planning project will focus on processes and products that will be essential for laying the foundation for effective implementation of a comprehensive strategic plan and the ultimate realization of improved outcomes for young children and their families. The Department of Health and Human Services has recently been notified that this project has been funded.
Source: ABSTRACT, Nebraska's Comprehensive Early Childhood Strategic Planning Project, Nebraska Department of Health and Human Services, 2003.

Three new wraparound programs –Integrated Care Coordination Units - for state wards have been funded by the Office of Protection and Safety, and provide new opportunities for youth in the

Protection and Safety system. We would like to see additional funds for the Professional Partner Program, which provides wraparound services for non-wards. In Region 3, cost savings from the ICCUs has been appropriated to prevent at risk children from becoming wards (i.e. custody relinquishment) by providing wraparound services. We hope this trend continues.

GOAL 2: FAMILY SUPPORT
ACHIEVED

Projects involving the support of families include: The Office of Protection and Safety and the Office of Mental Health, Substance Abuse and Addiction Services fund a new support activity called "Families Mentoring & Supporting Other Families", a joint initiative to request proposals from qualified sources to provide:

A. Strength-based, family centered, and partnership oriented supports to:
   1) parents across the State of Nebraska whose children have been made state wards, or are in a voluntary case, or
   2) parent who are involved with the department as a result of a report of abuse/neglect, or
   3) parents whose children are diagnosed with a serious emotional disturbance and substance dependence disorders.
B. The intent is to ensure that parents have a voice, ownership and access to the systems of care for their child (i.e. case plans, individual educational plans, treatment plans and any other care plan).

The outcomes for parents served are:
1. To have support of other families that are coping with similar challenges.
2. To reduce parental feelings of emotional and social isolation that sometimes occur in parenting a child with emotional and behavioral challenges.
3. To have referral sources to access the appropriate services for their child and other family members.
4. To be equal partners in the system of care.
5. To learn how to enhance communication and networking with the professionals involved in the case.

The program objectives are to support one parent organization within each of the service areas/regions, for all individual parent organizations awarded contracts to come together and form a consortium so there is some commonality and consistency between the 6 service areas/regions organizations and an opportunity for statewide issues to be addressed. HHS has a collaborative relationship with the consortium. The consortium members may be required to meet with HHS via telephone conference calls on a quarterly basis and in-person one-two times per year. They deliver parent to parent supports that are efficient, effective and responsive as well as tailored to the unique and individualized needs of the child and family and measure and demonstrate the parent outcomes outlined above.

All supports are community-based and provided at the local community level. Organizations must ensure supports have the capacity to address the unique culture of each family and child. Organizational supports need to recognize the importance of understanding the values, beliefs, and practices of diverse cultures. Organizations integrate diversity into their practices and products so

that interactions with individual children and their families can be mindful of, and honor, the family's home culture.

One organization has been selected from each of six service areas of Health and Human Services and the corresponding mental health and substance abuse regions to develop a program that will provide supports to targeted families (1) whose children have been made state wards, (2) are involved with the department as a result of a report of abuse/neglect, or (3) whose children are diagnosed with a severe emotional disturbance and substance dependence disorders.

In addition, NAMI –Nebraska has purchased the "Visions for Tomorrow" curriculum to provide education and support to families in southeast Nebraska. Visions for Tomorrow education workshops are designed for caregivers of children and adolescents who have been diagnosed with a brain disorder as well as those who exhibit behavior that strongly suggests such a diagnosis.

i. There is no charge for the course for the caregivers.
ii. Visions' teachers are caregivers themselves.
iii. The course has been designed and written by experienced caregivers, family members and professionals.
iv. The course balances basic psycho-education and skill training with self-care, emotional support and empowerment.

Purpose is to provide basic education and knowledge of various brain disorders, to provide general information for networking with support groups and dealing with the different systems of care and to provide basic information and methods needed to advocate for persons with brain disorders. The project is slated to begin in September of 2004.

Although the number family support projects continue to increase, a large number of caregivers of children with disabilities, including SED, continue to live in isolation without support. A large number of grandparents are now raising their grandchildren, and a proportionate number of those children have disabilities. Providers report that they are observing a trend in the number of grandparents who are raising their grandchildren. The grandparents have reported that programs which recognize the unique needs of older adults raising children with disabilities seem to be virtually nonexistent in Nebraska.

GOAL #3: INTEGRATION OF SERVICE SYSTEMS ACHIEVED

For younger children, Nebraska Health and Human Services has received assistance from U.S. Maternal and Child Health Bureau for the **State Maternal and Child Health Early Childhood Comprehensive Systems Grant Program**. Nebraska state agencies, in partnership with professional organizations, community-based providers, families, and advocates, have made significant progress in addressing various aspects of early childhood systems of care. Several initiatives have resulted in planning documents and pilot projects. A major challenge that remains is to achieve an integrated, comprehensive plan that addresses the five key components of: (1) access to health care and a medical home; (2) **mental health and socio-emotional development**;

(3) early care and education/child care; (4) parent education; and (5) family support. In addition, a number of other challenges are being faced in Nebraska that impact upon the health and well-being of Nebraska's young children and their families and the system that supports early childhood programs and services. Among these are an increasingly diverse populations and large expanses of rural and sparsely populated areas. In addition, gaps exist in data availability and utilization, including an absence of agreed-upon early childhood indicators.

The goal for this proposed project is to achieve optimum outcomes for Nebraska's young children and their families through comprehensive system planning and collaborative effort among stakeholders. The 2-year planning project focuses on processes and products that will be essential for laying the foundation for effective implementation of a strategic plan and the ultimate realization of improved outcomes for young children and their families. Objectives include:

1. Establish a planning structure and process that engages the full spectrum of early childhood stakeholders, with an emphasis on family involvement;
2. Develop vision and mission statements and identify key outcomes for young children and the early childhood system in each of the five essential components;
3. Develop a set of indicators linked to outcomes;
4. Identify and rank priority needs and issues in each of the five essential components;
5. Develop strategies and associated action plans for each of the priority needs and issues;
6. Obtain commitments to accept and implement the strategic plan from key policy makers; and
7. Develop a comprehensive plan for sustaining the effort.

A participatory planning process, using a comprehensive planning model, has been selected as the methodology. This model meets the criteria of bringing together various and diverse organizations and individuals to create consensus and make prudent decisions about the future of early childhood comprehensive systems. This model is based on six basic steps: (1) issue identification/orientation, (2) exploration/investigation, (4) defining the planning of task or goal setting, (4) policy formation, (5) programming, and (6) evaluation. A consultant will guide participants in the process, and provide technical assistance to build stakeholder capacity to carry out the plan and continue planning efforts in the future. A full-time project coordinator will work with an Advisory Committee, a Project Leadership Team, and eight Work Groups.

The Governor-appointed Early Childhood Interagency Coordinating Council (ECICC) serves as the Project Advisory Committee. The ECICC has done extensive work in examining early childhood care and education issues, and its membership represents a wide range of interests, including child care providers, state agencies, parents, business, health care providers, and others. In addition, a 20 – 30 member Project Leadership Team will engage representatives of state agencies, Tribal government, provider and family associations, advocacy groups, the business community, military installations, and other important stakeholders. Eight work groups will further facilitate involvement and coordination with state-level and community-based efforts. Planning activities will actively build on earlier and existing initiatives.

The project measures progress in achieving seven planning phase outcomes and five short-term implementation outcomes. The planning phase outcomes are: (1) linkages formed among system and community/client stakeholders; (2) planning structure and staff established and functional; (3) workgroups formed, oriented to process, and prepared to carry out assignments; (4) community/stakeholder vision and mission developed; (5) strategies consistent with vision and mission; (6) policy changes identified to drive implementation phase; and (7) public support for

change enhanced. The five short-term implementation outcomes are: (1) a model for shared decision making disseminated system wide; (2) improved capacity among stakeholders in the area of policy development; (3) information and administration infrastructure in place to increase exchanges; (4) system improvement resulting from training and coaching of stakeholders; and (5) ongoing stakeholder participation and data to improve early childhood systems planning.

The goal of this project is to achieve optimum outcomes for Nebraska's young children and their families through comprehensive system planning and collaborative effort among stakeholders. The focuses on processes and products that will be essential for laying the foundation for effective implementation of a comprehensive strategic plan and the ultimate realization of improved outcomes for young children and their families. **Source:** ABSTRACT, Nebraska's Comprehensive Early Childhood Strategic Planning Project, Nebraska Department of Health and Human Services.

The ICCU is a public care coordination collaborative that includes Department of Health and Human Services Division of Protection and Safety and Region III Behavioral Health Services Care Coordinators who will ensure that care is individualized and adhere to the following wraparound principles: A no reject/eject philosophy, comprehensive assessment to determine the child and family's needs, child and family team consisting of both professionals and non-professionals who know the child and family, a Care Coordinator, with a caseload of 1:10, to facilitate the child and family team, development of an Individualized Child/Family Support Plan based on the strengths of the child and family; strategies that are individualized to the child and family's needs and based on the family's cultural background. Through flexible funding, purchase of services and supports identified in the plan are made. Use of community teams to broker informal resources to support families and monitoring of outcomes and modification of strategies to produce better results are also used.

Other important system components include family operated support and advocacy organization for families of children with serious emotional and behavioral issues, the **Care Management Team** which provides utilization management/review, a strong cross agency **Program Evaluation** component which collects demographics, service utilization, cost, and outcome data, and the **ICCU Director's** with membership consisting of key representatives of the three system partners .
The children and adolescents served share the following characteristics:

- High functional impairments in multiple areas (e.g., school, home, community, self harm, substance abuse)
- Persistent problems over long term
- Multi-agency involvement
- High service costs (although they constitute less than 25% of the state ward population in Central Nebraska, they use almost 70% of the resources).
- Poor outcomes in traditional services

SECTION THREE:
ADULTS– ACCOMPLISHMENTS
PERFORMANCE INDICATORS

ADULT'S PLAN

Section III. Performance Goals and Action Plans to Improve the Service System
Criterion 1: Comprehensive Community-Based Mental Health Service Systems

(ii) Goals, Targets and Action Plans

Criterion 1: Comprehensive Community- based Mental Health Service Systems
GOAL: Maintain capacity of Community Support Services (2004)

FY 2005 Nebraska MENTAL HEALTH PLAN
Criterion 1: Comprehensive Community- based Mental Health Service Systems

GOAL: Increase capacity of Community Support Services

OBJECTIVE: In light of current Behavioral Health Reform, by June 30, 2005, the number of persons served with Serious Mental Illness receiving Mental Health Community Support Services will be increased.

The Performance Measure as presented in the Nebraska FY2005 Community Mental Health Services Block Grant Application

POPULATION: SMI Adults

Performance Indicator	**FY2003 Actual**	**FY2004 Projected**	**FY2004 Actual**	**FY2005 Target**
Value:	2,613	2,600		3,000

The performance measure needs to be revised. Based on the actuals reported by the six Regional Behavioral Health Authorities in September 2005, the following is the correct data for this measure.

Revised – November 2005

Performance Indicator	**FY2003 Actual**	**FY2004 Actual**	**FY2005 Actual**
Value:	2,364	2,352	2,453

Number of persons SMI who are receiving Mental Health Community Support (including case management) services

Value = all persons reported SMI receiving Mental Health Community Support

Data source: from Nebraska Division of Behavioral Health Services as reported by the six Regional Behavioral Health Authorities.

NOTE: In the report to the Behavioral Health Oversight Commission of the Legislature on October 14, 2005 regarding "People Served Per Month in Community Support - Mental Health" shows for Fiscal Year 2005 the following: July 2004 =1,857 … June 2005 = 2,160. This is an increase from July 2004 to June 2005 of 303 people served (16.3%).

Below is the complete report on Community Support – MH / FY03, FY04, and FY05 ACTUALS Number (#) and Percent (%) of Total for the Year of Persons Served.

Region	FY03	FY04	FY05	Population (2000)

	#	%	#	%	#	%	#	%
1	39	1.6%	68	2.9%	157	6.4%	90,410	5.3%
2	239	10.1%	242	10.3%	281	11.5%	102,311	6.0%
3	289	12.2%	363	15.4%	371	15.1%	223,143	13.0%
4	277	11.7%	293	12.5%	384	15.7%	216,338	12.6%
5	1,152	48.7%	957	40.7%	829	33.8%	413,557	24.2%
6	368	15.6%	429	18.2%	431	17.6%	665,454	38.9%
Totals	2,364	100%	2,352	100%	2,453	100%	1,711,213	100%
Source: as reported by the Six Regional Behavioral Health Authorities, September 2004; September 2005								

Persons Served means unduplicated count measuring every person who may be involved in services during the year funded ONLY by state and federal funds RECEIVED FROM THE DIVISION OF BEHAVIORAL HEALTH SERVICES (including services that Behavioral Health supplies the state match for Medicaid); some persons were already receiving services at the beginning of the year, while others will be admitted during the new fiscal year. This definition applies to both Fee for Service (FFS) and Non-Fee for Service (NFFS) services.

Criterion 2: Mental Health System Data Epidemiology
(ii) Goals, Targets and Action Plans

FY 2005 Nebraska MENTAL HEALTH PLAN
PERFORMANCE INDICATORS

GOAL: To maintain if not increase the number of people receiving Mental Health Services.

OBJECTIVE: To maintain if not increase the number of persons age 18 or older (unduplicated count) in FY2005 (increase program capacity under Behavioral Health Reform).

POPULATION: Adults receiving mental health services within the Nebraska Behavioral Health System (NBHS)

Magellan Behavioral Health Unduplicated Persons Served / Age 18+					
Performance Indicator	**FY2003 Actual**	**FY2004 Projected**	**FY2004 Actual**	**FY2005 Target**	**FY2005 Actual**
M H Services only	17,432	17,000	16,620	18,000	22,779

Data source: from Nebraska Division of Behavioral Health Services

Federal Uniform Reporting System / NE Implementation Report 2003, 2004, 2005
Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

- Data limited to community mental health as reported to Magellan Behavioral Health for the Nebraska Division of Behavioral Health Services

	2003	2004	2005

0-3 Years	245	179	92
4-12 years	1,052	595	1,017
13-17 years	1,136	1,002	1,329
18-20 years	924	1,062	925
21-64 years	15,899	15,014	19,811
65-74 years	346	342	397
75+ years	238	195	239
Not Available	25	7	1,407
Total	19,865	18,396	25,217
adults age 18 +	17,432	16,620	22,779

Criterion 4: Targeted Services to Rural and Homeless Populations
(ii) Goals, Targets and Action Plans

GOAL: With the Rural Mental Health Program, provide services to the rural residents of Nebraska impacted by the prolonged decline of the farm/rural economy in Nebraska.

OBJECTIVE: In FY2004, provide 2,500 counseling sessions to 800 people (individuals or families) under the crisis counseling vouchers program.

POPULATION: Residents of Nebraska's rural and frontier areas including farmers, ranchers, spouses, children, and others who are directly affected by the continued economic crisis.

Value: average number of sessions per individual/family

Numerator: unduplicated count / people served (individual or family)

Denominator: total number of counseling sessions

Performance Indicator:	FY2003 Actual	FY2004 Projected	FY2004 Actual	FY2005 Target
Value:	2.4	2.5	3.14	3.0
Numerator	845	800	901	850
Denominator	2025	2000	2834	2550

Discussion: In FY 2004, the entire $100,000 was used for the Voucher Program as the demand for vouchers increased significantly in rural Nebraska due to drought, increased production costs, and low farm prices.

Data source: from Nebraska Division of Behavioral Health Services

Criterion 5: Management Systems
(ii) Goals, Targets and Action Plans

Criterion 5: Management Systems
GOAL: At least maintain the Per Capita State Expenditures for Community Mental Health Services

FY 2005 Nebraska MENTAL HEALTH PLAN
PERFORMANCE INDICATORS

Population: SMI Adults
Criterion 5: Management Systems

GOAL: At least maintain the Per Capita State Expenditures for Community Mental Health Services

OBJECTIVE: By June 30, 2004, the per capita state expenditures for community mental health services will be maintained over $15.00

POPULATION: Total population

Per Capita State Expenditures for Community Mental Health Services

Numerator = FY2001 and FY2002 is "actual" Mental Health State Expenditures (as reported for the Maintenance of Effort section of the Block Grant Application)

Numerator Data source: Office of Mental Health, Substance Abuse and Addiction Services

Denominator = Total State population

Data Source: Nebraska Databook, Last Updated on 5/21/01 based on data from U. S. Bureau of the Census Web site (www.census.gov) 2001 <http://info.neded.org/stathand/bsect8.htm>

Performance Indicator:	**FY 2003 Actual**	**FY2004 Objective**	**FY2004 Actual**	**FY2005 Target**
Value:	$16.97	$17.46		$18.24
Numerator	$29,036,852	$29,874,816		$31,207,611
Denominator	1,711,263	1,711,263		1,711,263

Performance Indicator:	**FY 2003 Actual**	**FY2004 Actual**	**FY2005 Actual/ Estimated**
Value:	$16.97	$20.85	$21.60
Numerator	$29,036,852	$35,678,871	$36,970,889
Denominator	1,711,263	1,711,263	1,711,263

Section III. Maintenance of Effort (MOE)

DATA REPORTED BY: State Fiscal Year (July 1 to June 30)

State Expenditures for Mental Health Services		
Actual 2003	Actual 2004	Actual/Estimated 2005 *
$29,036,852	**$35,678,871**	**$36,970,889**

SECTION FOUR:
CHILDREN – ACCOMPLISHMENTS
PERFORMANCE INDICATORS

CRITERION 1: COMPREHENSIVE COMMUNITY- BASED MENTAL HEALTH SERVICE SYSTEMS

GOAL #1:	Maintain capacity of Professional Partner (wraparound) program for children with serious emotional disturbance.
POPULATION:	Children and adolescents with serious emotional and behavioral disorders
OBJECTIVE:	The number of children participating in Professional Partner wraparound program will be maintained.
CRITERION:	#1 Comprehensive, community-based mental health system
BRIEF NAME:	Children enrolled in Professional Partner
INDICATOR:	The number of children participating in Professional Partner services (age 0-20)
MEASURE:	Count of number of children participating in Professional Partners as of June 30 of each year.
SOURCE OF INFORMATION:	FY04 Actuals; Magellan data for FY2005

Performance Indicator	**FY 2004 Actual**	**FY 2005 Estimated**	**FY 2005 Actual**	**% Attain**
Children in Professional Partner	849*	345	427	

*Includes children served under Federal System of Care Grant; in FY05, many of those children were transferred and served in Integrated Care Coordination Units (wraparound) funded through Protection and Safety

Criterion 2: Mental Health System Data Epidemiology

GOAL #2:	To maintain the number of persons age 0-17 receiving services through the Nebraska Behavioral Health System.			
POPULATION:	Children and adolescents receiving Mental Health Services			
OBJECTIVE:	The number of children receiving services will be maintained			
CRITERION:	#1 Comprehensive, community-based mental health system			
BRIEF NAME:	Persons age 0-17 receiving services			
INDICATOR:	The number of children receiving services			
MEASURE:	Count of number of children receiving services			
SOURCE OF INFORMATION:	Magellan			
Performance Indicator	**FY 2004 Actual**	**FY 2005 Estimated**	**FY 2005 Actual**	**% Attain**
Children receiving services	1,776	2262	2,438	662 (37.3%) increase from FY2004 to FY2005

Criterion 3: Children's Services

GOAL #3:	To provide a system of integrated services for all children with serious emotional disorders who have multiple and complex needs
POPULATION:	Children with serious emotional disorders who are wards of the state
OBJECTIVE:	The number of children who are in the custody of the state and who receive integrated care coordination will increase by 5%.
CRITERION:	Children's Services
BRIEF NAME:	Integrated care coordination for state wards with SED
INDICATOR:	The number of children receiving integrated care coordination
MEASURE:	Count of children receiving integrated care coordination
SOURCE OF INFORMATION:	ICCU Director
SIGNIFICANCE:	Emerging body of research indicates intensive case management using the wraparound approach can be effective in ensuring appropriate services and reducing expenses of using high cost services

Performance Indicator:	FY2005 Actual	FY 2004 Actual	FY2005 Estimated	FY2005 Actual
Value: Number of wards in ICC	203	500	1000	1527

Criterion 4: Targeted Services to Rural and Homeless Populations

GOAL #4: To provide services to all children in non-Metropolitan areas.
POPULATION: Children receiving services through the "Voucher Program" in non-Metro areas
OBJECTIVE: The number of children in non Metropolitan areas receiving services will be maintained.
CRITERION: Targeted Services to Rural and Homeless Populations
BRIEF NAME: Non Metropolitan children
INDICATOR: Number of children receiving "Voucher" services
MEASURE: Count of Non-Metropolitan children receiving services
SOURCE OF INFORMATION: Magellan for FY2004 and FY2005

1. Performance Indicator	3. FY 2004 Actual	FY 2005 Estimated	FY2005 Actual	% Attain
Number of children in non-Metropolitan areas receiving services	1264	1190	1377	Increase 113 (8.9%) from FY2004 to FY2005

Criterion 5: Management Systems
GOAL: At least maintain the Per Capita State Expenditures for Community Mental Health Services
OBJECTIVE: By June 30, 2004, there will be at least the same level of spending in per capita state expenditures for children's community mental health services at $8.82.
POPULATION: Total children's population ages 0-17 years.
Per Capita State Expenditures for Community Mental Health Services
Numerator = Mental Health State Expenditures (as reported for the Maintenance of Effort section of the Block Grant Application)
Data source: Office of Mental Health, Substance Abuse and Addiction Services
Denominator = per Capita ...Total children's population ages 0-17 years (450, 242)
Data Source: Nebraska Databook, Last Updated on 5/21/01 based on data from U. S. Bureau of the Census Web site (www.census.gov) 2001 <http://info.neded.org/stathand/bsect8.htm >.

Set-Aside for Children's Mental Health Services
DATA REPORTED BY: State Fiscal Year (July 1 to June 30)

1. Performance Indicator	3. FY 2004 Actual	FY 2005 Estimated	FY 2005 Actual	% Attain
Value:	8.09	7.62	7.62	-0.47 (-5.8%)
Numerator	$3,642,336	$3, 429,684	$3,429,684	
Denominator	450,242	450,242	450,242	

From the Nebraska Community Mental Health Services Block Grant Application FY 2006
Section II. Set-Aside for Children's Mental Health Services

State Expenditures for Children's Services			
Calculated 1994	Actual 2003	Actual 2004	Actual/Estimated 2005 *
$620,801	**$3,872,010**	**$3,642,336**	**$3,429,684**

Federal Requirements: CMHS Core Performance Indicators

APPLIES TO BOTH CHILDREN AND ADULTS

This also represents Nebraska's response to the requirements for submitting the National Outcome Measures (NOMs) per the Federal Review of the FY2006 Community Mental Health Services Block Grant Application in Detroit, MI on October 25, 2005.

NOM #1. Increased Access to Services*	Number of Persons Served by Age, Gender, and Race/Ethnicity

Federal Requirements / CMHS Core Performance Indicators (2004)
GOAL 1. Increased Access to Services

POPULATION: The persons served in mental health services in the Nebraska Behavioral Health System funded by the Nebraska Division of Behavioral Health Services as reported within the Magellan Behavioral Health Information System

Value: Total Persons Served (both children and adults) as reported on URS Table 2a & 2B

Performance Indicator:	FY2003 Actual	FY2004 Actual	FY2005 Target	FY2005 Actual
Value:	19,865	18,396	19,000	25,217

Discussion: Per the July 7, 2004 conference call with Deborah Baldwin on block Grant Plans . Applications for FY2005, the performance measure is limited to just the number of persons served. The Age, Gender, and Race/Ethnicity is not included.

Data source: from Nebraska Division of Behavioral Health Services
NE Uniform Reporting System 2003 / Table 2A. Profile of Persons Served

NE URS 2003, 2004, 2005
Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

	2003	2004	2005
0-3 Years	245	179	92
4-12 years	1,052	595	1,017
13-17 years	1,136	1,002	1,329
18-20 years	924	1,062	925
21-64 years	15,899	15,014	19,811
65-74 years	346	342	397
75+ years	238	195	239
Not Available	25	7	1,407
Total	19,865	18,396	25,217

NOM #2. Reduced Utilization of Psychiatric Inpatient Beds*	Decreased Rate of Readmission to State Psychiatric Hospitals within 30 days and 180 days

Federal Requirements / CMHS Core Performance Indicators (2004)

PPG Core Performance Indicators*		Relevant Criterion	DIG Tables Basic & Developmental	PART
INDICATORS EXPECTED IN 2005 OR COMPLETE STATE LEVEL DATA REPORTING CAPACITY CHECKLIST				
2. Reduced Utilization of Psychiatric Inpatient Beds	Decreased Rate of Readmission to State Psychiatric Hospitals within 30 days and 180 days	Criteria 1 and 3	Developmental Table 20A	Yes

GOAL 2. Reduced Utilization of Psychiatric Inpatient Beds

2. Reduced Utilization of Psychiatric Inpatient Beds*	Decreased Rate of Readmission to State Psychiatric Hospitals within 30 days and 180 days

POPULATION: Adults, Age 18 or older, Inpatient at the State Psychiatric Hospitals
Lincoln Regional Center, Norfolk Regional Center, Hastings Regional Center
Does not include transfers between regional centers or persons discharged for short-term treatment in a general hospital who are expected to return.

GOAL: Reduced Utilization of Psychiatric Inpatient Beds

OBJECTIVE: By June 30, 2006, the percentage of re-admissions to the Regional Centers decreased by 5%.
Value: Percentage of persons readmitted to Regional Centers within 30 days of discharge
Numerator: Readmitted within 30 days or within 180 days
Denominator: Number of discharges

Percent of Discharges from State Regional Center inpatient units who were **Readmitted within 30 days of discharge****

FY2003 actual	FY2004 actual	FY2005 estimate	FY2006 target	
6.1%	5.1%	3.6%	3.4%	Value
64	49	29*	28	Readmitted within 30 days
1,048	952	812	812	Number of discharges

Percent of Discharges from State Regional Center inpatient units who were **Readmitted within 180 days of discharge****

FY2003 actual	FY2004 actual	FY2005 estimate	FY2006 target	
18.1%	16.1%	Not Av.	15%	Value
190	153	Not Av.	122	Readmitted within 180 days
1,048	952	Not Av.	812	Number of discharges

* estimated, based on 11 months of readmission data

** Does not include transfers between regional centers or persons discharged for short-term treatment in a general hospital who are expected to return.
Prepared by Paula Hartig, July 20, 2005; Research and Performance Measurement; Financial Services Division; HHSS – Finance & Support

NOM #3. Use of Evidence-Based Practices*	Number of Evidence-based Practices Provided by State Number of Persons Receiving Evidence-based Practice Services

At this time, Nebraska does not have the capacity to report on this measure.

NOM #4. Client Perception of Care*	Clients Reporting Positively About Outcomes

Federal Requirements / CMHS Core Performance Indicators (2004)

PPG Core Performance Indicators*		Relevant Criterion	DIG Tables Basic & Developmental	PART
INDICATORS EXPECTED IN 2005 OR COMPLETE STATE LEVEL DATA REPORTING CAPACITY CHECKLIST				
4. Client Perception of Care	Clients Reporting Positively About Outcomes	Criteria 1 and 3	Basic Table 11	Yes

GOAL: Increase the Percent Reporting Positively About Outcomes.
OBJECTIVE: By June 30, 2005, increase the number of consumers responding Positively About Outcomes in the annual Nebraska Behavioral Health Consumer Survey.
POPULATION: all consumers with valid addresses within the Magellan Behavioral Health data base who do respond to the annual Nebraska Consumer Survey.

Value: the percentage responding positively to the
Numerator: average of positive responses to the MHSIP Consumer Survey: Perceptions of Outcomes questions (21. I deal more effectively with daily problems; 22. I am better able to control my life; 23. I am better able to deal with crisis; 24. I am getting along better with my family; 25. I do better in social situation; 26. I do better in school and/or work; 27. My housing situation has improved; 28. My symptoms are not bothering me as much).
Denominator: total number of responses
Numerator and Denominator Data Source: Nebraska annual consumer survey as reported on Uniform Reporting System / Implementation Report - Table 11. Summary Profile of Client Evaluation of Care using the official MHSIP consumer survey posted on www.mhsip.org.

Adult Consumer Survey Results

Performance Indicator:	**FY 2003 Actual**	**FY2004 Actual**	**FY 2005 Actual**
Value:	71.5%	89%	91%
Numerator	344	554	669
Denominator	481	620	732

Child/ Adolescent Consumer Survey Results

Performance Indicator:	**FY 2003 Actual**	**FY2004 Actual**	**FY 2005 Actual**
Value:	56.8%	53%	85%
Numerator	21	35	200
Denominator	37	66	235

Data source: from Nebraska Division of Behavioral Health Services
Nebraska 2003, 2004, and 2005 Uniform Reporting System
Table 11: Summary Profile of Client Evaluation of Care

Federal Requirements / CMHS Core Performance Indicators (2004)

PPG Core Performance Indicators*		Relevant Criterion	DIG Tables Basic & Developmental	PART
INDICATORS ENCOURAGED TO BE INCLUDED IN THE STATE PLAN IF STATE HAS CAPACITY TO REPORT				
7. Service Capacity	Number of Persons with SMI/SED	Criterion 2	Developmental Table 14A	No

URS Table 14A (Nebraska FY2003, 2004, 2005 Implementation Report).
Profile of Persons with SMI/SED served - This table requests counts for persons with SMI or SED using the definitions provided by the CMHS.

	2,003	2,004	2,005
0-3 Years	230	84	84
4-12 years	879	37	967
13-17 years	1,052	152	1,250
18-20 years	318	231	645
21-64 years	7,734	6,336	14,871
65-74 years	169	176	311
75+ years	87	71	176
Not Available	0	2	911
Total	10,469	7,089	19,215

GOAL: Number of Persons with SMI
POPULATION: Adults with serious mental illness served in mental health services in the Nebraska Behavioral Health System funded by the Nebraska Division of Behavioral Health Services as reported within the Magellan Behavioral Health Information System

Value: Total persons with SMI or SED Served as reported on URS Table 14a

Performance Indicator:	FY2003 Actual	FY2004 Actual	FY2005 Target	FY2005 Actual
Value:	10,469	7,089	10,500	19,215

Data source: from Nebraska Division of Behavioral Health Services
NE Uniform Reporting System 2003 / Table 14A. Profile of Persons with SMI/SED served by Age, Gender and Race/Ethnicity

Nebraska State Advisory Committee on Mental Health Services

November 14, 2005

LouEllen Rice
Grants Management Office, Room 7-1079
Division of Grants Management
Substance Abuse and Mental Health Services Administration
One Choke Cherry Road
Rockville, MD 20857

Dear Ms. Rice

This letter is intended to verify that on November 9, 2005, the Nebraska State Advisory Committee on Mental Health Services met in Lincoln, Nebraska and reviewed the Nebraska State Plan Implementing Report for FY2005. The plan was presented to the committee, and its contents were discussed. The committee also heard comments from the public regarding the Implementing Report.

After a good discussion by both the committee and the public, there were no issues of concern raised, nor were there any suggestions for changes or amendments to the plan. It was the consensus of the Council to support submission of the report.

Sincerely,

Allen Bartels RNC, MS
Chair, Nebraska State Advisory Committee on Mental Health Services

PART E – UNIFORM DATA ON PUBLIC MENTAL HEALTH SYSTEM

State Level Data Reporting Capacity Checklist – FY2004 State Reports

Please complete the following form indicating the capacity of the State Mental Health Authority to report the following data elements.

Data Element	Can the State provide this data element currently? (Yes/No)	IF YES,			IF NO,	
		Using Federal CMHS definitions/ categories? (Yes/No)	Using State definitions/ categories, if different? (Yes/No)	Does the State collect these data at the individual client level? (Yes/No)	Does the State intend to develop a reporting capacity for this data element? (Yes/No)	If Yes, by when will this capacity be in place? (Calendar Year)
Age	YES	YES		YES		
Gender	YES	YES		YES		
Race/Ethnicity Categories						
New Federal Race and Hispanic Origin Categories are Used in Community Settings	YES		YES	YES		
New Federal Race and Hispanic Origin Categories are Used in State Hospitals	NO				UNKNOWN	
Living Situation Categories						
Homeless Status of Persons Served in the Community	YES	YES		YES		
Persons Served - State psychiatric hospitals	YES		YES	YES		
Persons Served - Other psychiatric hospitals ++	NO				UNKNOWN	
Employment Status Categories						
Full time or part time Competitive Employment	YES	YES		YES		
Unemployed	YES	YES		YES		
- Not in Labor Force	YES	YES		YES		

Data Element	Can the State provide this data element currently? (Yes/No)	IF YES, Using Federal CMHS definitions/ categories? (Yes/No)	IF NO, Using State definitions/ categories, if different? (Yes/No)	Does the State collect these data at the individual client level? (Yes/No)	Does the State intend to develop a reporting capacity for this data element? (Yes/No)	If Yes, by when will this capacity be in place? (Calendar Year)
Patient Funding Support Categories						
Persons Served Through Medicaid Only	NO				UNKNOWN	
Persons Served Through Other Funding Sources Only	NO				UNKNOWN	
Persons Served by Both Medicaid and Non-Medicaid Sources	NO				UNKNOWN	
Client Turnover Status Categories						
State Hospitals - Admissions	YES		YES	YES		
State Hospital B Discharges	YES		YES	YES		
State Hospital B Average length of service (ALOS) (discharges)	YES		YES	YES		
State Hospital B ALOS (residents at end of year)	YES		YES	YES		
Other Inpatient Settings – Admissions ++	NO				UNKNOWN	
Other Inpatient Settings – Discharges	NO				UNKNOWN	
Other Inpatient Settings - ALOS (discharges)	NO				UNKNOWN	
Other Inpatient Settings - ALOS (residents at end of year)	NO				UNKNOWN	

Data Element	Can the State provide this data element currently? (Yes/No)	IF YES, Using Federal CMHS definitions/ categories? (Yes/No)	IF NO, Using State definitions/ categories, if different? (Yes/No)	Does the State collect these data at the individual client level? (Yes/No)	Does the State intend to develop a reporting capacity for this data element? (Yes/No)	If Yes, by when will this capacity be in place? (Calendar Year)
Block Grant Non-Direct Service Expenditure Categories						
Technical Assistance	YES	YES		YES		
Planning Council	YES	YES		YES		
Administration	YES	YES		YES		
Data collection/ reporting	YES	YES		YES		
Other Activities	YES	YES		YES		
Dual Diagnosis Status Categories						
Adults Served Who Had a Diagnosis of Substance Abuse and MH	YES	YES		YES		
Adults with SMI Served Who Had a Diagnosis of SA and MH	YES	YES		YES		
Children Served Who Had a Diagnosis of SA and MH	YES	YES		YES		
Children with SED Served Who Had a Diagnosis of SA and MH	YES	YES		YES		

++ Regarding Other psychiatric hospitals: Nebraska captures these data as part of the Magellan Behavioral Health Data System under the community programs. However, there is no data capture for “Other Psychiatric Hospitals” services not funded by State Mental Health Authority.

State Level Data Reporting Capacity Checklist - Developmental Tables

Please complete the following form indicating the capacity of the State Mental Health Authority to report the following data elements.

Data Element	Can the State provide this data element currently? (Yes/No)	IF YES,			IF NO,	
		Using Federal CMHS provisional definitions/ categories? (Yes/No)	Using State definitions/ categories, if different? (Yes/No)	Does the State collect these data at the individual client level? (Yes/No)	Does the State intend to develop a reporting capacity for this data element? (Yes/No)	If Yes, by when will this capacity be in place? (Calendar Year)
Operational Definition to Identify Adults with SMI	YES		YES	YES		
Operational Definition to Identify Children with SED	YES		YES	YES		
Living arrangement - Living in Private Residence	YES		YES	YES		
Living arrangement- Living in Foster Care	YES		YES	YES		
Living arrangement - other 24-hr residential	YES		YES	YES		
Evidence-Based Practices						
Supported Housing Services	NO				YES	2006
Supported Employment Services	NO				YES	2007
Assertive Community Treatment (ACT) programs	YES		YES	YES		
New Generation Medications in State Hospitals	NO				UNKNOWN	
New Generation Medications in Community Settings	NO				UNKNOWN	
					UNKNOWN	

Data Element	Can the State provide this data element currently? (Yes/No)	IF YES,			IF NO,	
		Using Federal CMHS provisional definitions/ categories? (Yes/No)	Using State definitions/ categories, if different? (Yes/No)	Does the State collect these data at the individual client level? (Yes/No)	Does the State intend to develop a reporting capacity for this data element? (Yes/No)	If Yes, by when will this capacity be in place? (Calendar Year)
Integrated Treatment for Persons with Mental Illness and Substance Abuse	YES					
Therapeutic foster care	NO				UNKNOWN	
Family PsychoEducation	NO				UNKNOWN	
Illness Management and Recovery Skills	NO				UNKNOWN	
Outcome Measures						
School attendance – Children's	NO				UNKNOWN	
School Performance – Children	NO				UNKNOWN	
Criminal justice involvement – Adults	NO				UNKNOWN	
Criminal justice involvement – Children	NO				UNKNOWN	

PART E – UNIFORM DATA ON PUBLIC MENTAL HEALTH SYSTEM

UNIFORM REPORTING TABLES

Table 1. Profile of the State Population by Diagnosis

This table summarizes the estimates of adults residing within the State with serious mental illness (SMI) and children residing within the state with serious emotional disturbances (SED). The table calls for estimates for two time periods, one for the report year and one for three years into the future. CMHS will provide this data to States based on the standardized methodology developed and published in the Federal Register and the State level estimates for both adults with SMI and children with SED.

Table 1.		
Report Year:		
State Identifier:		
	Current Report Year	**Three Years Forward**
Adults with Serious Mental Illness (SMI)		
Children with Serious Emotional Disturbances (SED)		

Note: This Table will be completed for the States by CMHS.

For Nebraska

From: URS Table 1: Number of Persons with Serious Mental Illness, age18 and older, by State, 2004

Adults with Serious Mental Illness (SMI)	
Civilian Population Age 18+ Population 2004 =	1,305,191
Civilian Population with SMI (5.4%) =	70,480

Children with Serious Emotional Disturbances (SED)
From: URS Table 1: Estimated Number of Children and Adolescents, Age 9 to 17, with Serious Emotional Distrubance, by State, 2004

Number of Youth 9 to 17 =	221,460
Level of Functioning Score= 50 [Mean of Lower Limit (11,073) / Upper Limit (15,502)] =	13,288
Level of Functioning Score=60 [Mean of Lower Limit (19,931) / Upper Limit (24,361)] =	22,146

Source: http://www.nri-inc.org/SDICC/SDICC05/05files.cfm
2005 SMI Estimates for Table 1
2005 SED Estimates for Table 1

Federal Uniform Data Definitions FY2004 State Reports
Revised August 2005

Serious Mental Illness means

Pursuant to section 1912(c) of the Public Health Service Act, adults with serious mental illness SMI are persons: (1) age 18 and over and (2) who currently have, or at any time during the past year had a diagnosable mental behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV or their ICD-9-CM equivalent (and subsequent revisions) with the exception of DSM-IV "V" codes, substance use disorders, and developmental disorders, which are excluded, unless they co-occur with another diagnosable serious mental illness. (3) That has resulted in functional impairment, which substantially interferes with or limits one or more major life activities. Federal Register Volume 58 No. 96 published Thursday May 20, 1993 pages 29422 through 29425.

Serious Emotional Disturbance means

Pursuant to section 1912(c) of the Public Health Service Act "children with a serious emotional disturbance" are persons: (1) from birth up to age 18 and (2) who currently have, or at any time during the last year, had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R. Federal Register Volume 58 No. 96 published Thursday May 20, 1993 pages 29422 through 29425.

Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

This table provides an aggregate profile of persons in the reporting year. The reporting year should be the latest state fiscal year for which data are available. This profile is based on a client receiving services in programs provided or funded by the state mental health agency. The client profile takes into account all institutional and community services for all such programs. Please provide unduplicated counts if possible.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Please enter the "total" in the appropriate row and column and report the data under the categories listed.

Table 2.														
Report Year:	2005													
State Identifier:	NE													
	Total				American Indian or Alaska Native			Asian			Black or African American			
	Female	Male	Not Available	Total	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	
0-3 Years	46	46	0	92	1	1					5	7		
4-12 years	359	658	0	1017	6	48		8	3		30	64		
13-17 years	562	767	0	1329	26	38		5	5		31	57		
18-20 years	388	537	0	925	6	28		3	2		31	32		
21-64 years	9585	10226	0	19811	300	361		50	60		710	1015		
65-74 years	264	133	0	397	3	9		5			9	4		
75+ years	156	83	0	239	2	2		2				2		
Not Available	624	783	0	1407	19	41		6	5		21	71		
Total	11984	13233	0	25217	363	528	0	79	75	0	837	1252	0	

Are these numbers unduplicated? ☑ Unduplicated ☐ Duplicated: between Hospitals and Community ☐ Duplicated Among Community Programs ☐ Duplicated between children and adults ☐ Other: describe:

Comments on Data (for Age):	Age was determined by a calculation made by substracting reported birthday from January 1, 2005.
Comments on Data (for Gender):	
Comments on Data (for Race/Ethnicity):	More than one race reflect individuals who reported being "biracial" Others includes the response of people for which there was no category available
Comments on Data (Overall):	The quality of the data could be improved. There are a large number of "input" errors and several of the indicators do not reflect need information.

Table 2A. Profile of

This table provides a
available. This profile
into account all institu

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Table 2.
Report Year:
State Identifier:

	Native Hawaiian or Other Pacific Islander			White			Hispanic * *use only if data for Table 2b are not available.*		
	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available
0-3 Years				37	31				
4-12 years		1		295	503				
13-17 years	1	3		455	605				
18-20 years				328	432				
21-64 years	2	5		8031	8025				
65-74 years				231	111				
75+ years				141	74				
Not Available				549	597				
Total	3	9	0	10067	10378	0	0	0	0

Are these numbers ur

Comments on Data (for Age):
Comments on Data (for Gender):
Comments on Data (for Race/Ethnicity):
Comments on Data (Overall):

Table 2A. Profile of

This table provides a
available. This profile
into account all institu

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Please enter the "tota

Table 2.
Report Year:
State Identifier:

	More Than One Race Reported			Race Not Available		
	Female	Male	Not Available	Female	Male	Not Available
0-3 Years				3	7	
4-12 years				20	39	
13-17 years	1	9		43	50	
18-20 years	1	1		19	42	
21-64 years	5	8		487	752	
65-74 years				16	9	
75+ years				11	5	
Not Available		4		29	65	
Total	7	22	0	628	969	0

Are these numbers ur

Comments on Data (for Age):
Comments on Data (for Gender):
Comments on Data (for Race/Ethnicity):
Comments on Data (Overall):

Table 2B. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

Of the total persons served, please indicate the age, gender and the number of persons who are Hispanic/Latino or not Hispanic/Latino. Total persons served would be the total as indicated in Table 2A.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Please enter the "total" in the appropriate row and column and report the data under the categories listed.

Table 2.													
Report Year:	2005												
State Identifier:	NE												
	Not Hispanic or Latino			Hispanic or Latino			Hispanic or Latino Origin Not Available			Total			
	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Total
0 - 3 Years	41	40		3	6		2			46	46	0	92
4 - 12 years	332	606		25	49		2	3		359	658	0	1017
13 - 17 years	515	703		42	52		5	12		562	767	0	1329
18 - 20 years	369	497		19	30			10		388	537	0	925
21-64 years	9003	9392		387	532		195	302		9585	10226	0	19811
65-74 years	251	124		8	5		5	4		264	133	0	397
75+ years	143	78		4	1		9	4		156	83	0	239
Not Available	588	702		26	61		10	20		624	783	0	1407
Total	11,242	12,142	0	514	736	0	228	355	0	11984	13233	0	25217
Comments on Data (for Age):													
Comments on Data (for Gender):													
Comments on Data (for Race/Ethnicity):													

Table 3. Profile of Persons served in the community mental health setting, State Psychiatric Hospitals and Other Settings

This table provides a profile for the clients that received public funded mental health services in community mental health settings, in state psychiatric hospita

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 3.												
Report Year:	2005											
State Identifier:	NE											
	Age 0-17			Age 18-20			Age 21-64			Age 65+		
Table 3. Service Setting	**Female**	**Male**	**Not Available**	**Female**	**Male**	**Not Available**	**Female**	**Male**	**Not Available**	**Female**	**Male**	**Not Available**
Community Mental Health Programs	1049	1633		388	537		9585	10226		430	224	
State Psychiatric Hospitals	29	112		14	50		304	690		16	23	
Other Psychiatric Inpatient												
Residential Treatment Center for Children	9	8		4	3							
Comments on Data (for Age):												
Comments on Data (for Gender):												
Comments on Data (Overall):												

Note: Clients can be duplicated between Rows: E.g., The same client may be served in both state psychiatric hospitals and community mental health centers during the same year and thus would be reported in counts for both rows.

Instructions:

1 States that have county psychiatric hospitals that serve as surrogate state hospitals should report persons served in such settings as receiving services in state hospitals.

2 If forensic hospitals are part of the state mental health agency system include them.

3 Persons who receive non-inpatient care in state psychiatric hospitals should be included in the Community MHH Program Row

4 Persons who receive inpatient psychiatric care through a private provider or medical provider licensed and/or contracted through the SMHA should be counted in the "OtherPsychiatric Inpatient" row. Persons who receive Medicaid funded inpatient services through a provider that is not licensed or contracted by the SMHA should not be counted here.

5 A person who is served in both community settings and inpatient settings should be included in both rows

6 RTC: CMHS has a standardized definition of RTC for Children: “An organization, not licensed as a psychiatric hospital, whose primary purpose is the provision of individually planned programs of mental health treatment services in conjunction with residential care for children and youth primarily 17 years old and younger. It has a clinical program that is directed by a psychiatrist, psychologist, social worker, or psychiatric nurse who has a master’s degree or doctorate. The primary reason for the admission of the clients is mental illness that can be classified by SDM-IV codes-other than the codes for mental retardation, developmental disorders, and substance-related disorders such as drug abuse and alcoholism (unless these are co-occurring with a mental illness).”

Table 3. Profile

This table provi ls, in other psychitric inpatient programs, and in residential treatment centers for children.

PLEASE D

Table 3.							
Report Year:							
State Identifier:							
	Age Not Available			**Total**			
Table 3. Service Setting	**Female**	**Male**	**Not Available**	**Female**	**Male**	**Not Available**	**Total**
Community Me Health Program	532	613		11,984	13,233	0	25,217
State Psychiatr Hospitals	12	76		375	951	0	1,326
Other Psychiatr Inpatient				0	0	0	0
Residential Tre Center for Child	4	3		17	14	0	31
Comments on Da Age):							
Comments on Da Gender):							
Comments on Da (Overall):							
Note: Clients car same year and th							

Instructions:

1

2

3

4

5

6

Table 4. Profile of Adult Clients by Employment Status

This table describes the status of adults clients served in the report year by the public mental health system in terms of employment status. The focus is on employment for the working age population, recognizing, however, that there are clients who are disabled, retired or who are homemakers, care-givers, etc and not a part of the workforce. These persons will be reporting in the "Not in Labor Force" category. This category has two subcategories: retired and other. (The totals of these two categories should equal the number in the row for "Not in Labor Force".) Unemployed refers to persons who are looking for work but have not found employment. **Data should be reported for clients in non-institutional settings at time of discharge or last evaluation.**

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 4.																
Report Year:	2005															
State Identifier:	NE															
	18-20			**21-64**			**65+**			**Age Not Available**			**Total**			
Adults Served	**Female**	**Male**	**Not Available**	**Female**	**Male**	**Not Available**	**Female**	**Male**	**Not Available**	**Female**	**Male**	**Not Available**	**Female**	**Male**	**Not Available**	**Total**
Employed: Competitively Employed Full or Part Time (includes Supported Employment)	121	134		3159	3891		49	36		178	144		3507	4205	0	7712
Unemployed	81	110		2297	2787		66	34		90	123		2534	3054	0	5588
Not In Labor Force: Retired, Sheltered Employment, Sheltered Workshops, Other (homemaker, student, volunteer, disabled, etc.)	186	290		3999	3350		298	145		260	342		4743	4127	0	8870
Not Available		3		130	198		17	9		4	4		151	214	0	365
Total	388	537	0	9585	10226	0	430	224	0	532	613	0	10935	11600	0	22535

How Often Does your State Measure Employment Status? ☑ At Admission ☐ At Discharge ☐ Monthly ☐ Quarterly ☐ Other: describe: _____

What populations are included: ☐ All clients ☐ Only selected groups: describe:

Comments on Data (for Age):	
Comments on Data (for Gender):	
Comments on Data (Overall):	

Table 5A. Profile of Clients by Type of Funding Support

This table provides a summary of clients by Medicaid coverage. Since the focus of the reporting is on clients of the public mental health service delivery system, this table focuses on the clientele serviced by public programs that are funded or operated by the State Mental Health Authority. Persons are to be counted in the Medicaid row if they received a service reimbursable through Medicaid.

B

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Please note that the same person may be served in both Medicaid and Non-Medicaid programs during the same reporting period.

Table 5A													
Report Year:	2005												
State Identifier:	NE												
	Total				American Indian or Alaska Native			Asian			Black or African American		
	Female	Male	Not Available	Total	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available
Medicaid (only Medicaid)	1158	869	0	2027	28	22		6	9		116	99	
Non-Medicaid Sources (only)	9776	10865	0	20641	305	463		62	57		619	969	
People Served by Both Medicaid and Non-Medicaid	512	445	0	957	11	4		4	1		32	20	
Medicaid Status Not Available	538	1054	0	1592	19	39		7	8		70	164	
Total Served	11984	13233	0	25217	363	528	0	79	75	0	837	1252	0

☐ Data based on Medicaid Paid Services ☐ Data Based on Medicaid Eligibility, not Medicaid Paid Services ☐ Data are Duplicated

Comments on Data (for Age):	
Comments on Data (for Gender):	
Comments on Data (Overall):	

Each row should have a unique (unduplicated) count of clients: (1) Medicaid Only, (2) Non-Medicaid Only, (3) Both Medicaid and Other Sources funded their treatment, and (4) Medicaid Status Not Available).
If a state is unable to unduplicate between People whose care is paid by Medicaid, then they should report all data into the People Served by Both Medicaid and Other Sources and would check the box, People Served by Both is a duplicated count.

Table 5A. Profile of

This table provides a
focuses on the client
they received a servi

PLEASE DO N

Please note that the sa

Table 5A
Report Year:
State Identifier:

	Native Hawaiian or Other Pacific Islander			White			Hispanic * *use only if data for Table 5b are not available.*			More Than One Race Reported			Race Not Available		
	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available
Medicaid (only Medicaid)	1	2		956	705								51	32	
Non-Medicaid Sources (only)	2	7		8350	8697								438	672	
People Served by Both Medicaid and Non-Medicaid				432	397								33	23	
Medicaid Status Not Available				329	579					7	22		106	242	
Total Served	3	9	0	10067	10378	0	0	0	0	7	22	0	628	969	0

Comments on Data (for Age):
Comments on Data (for Gender):
Comments on Data (Overall):

Each row should hav
and (4) Medicaid Sta
If a state is unable to
Sources and would c

Table 5B. Profile of Clients by Type of Funding Support

Of the total persons covered by Medicaid, please indicate the gender and number of persons who are Hispanic/Latino or not Hispanic/Latino. Total persons covered by Medicaid would be the total indicated in Table 5A.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Please note that the same person may be served in both Medicaid and Non-Medicaid programs during the same reporting period.

Table 5B.													
Report Year:	2005												
State Identifier:	NE												
	Not Hispanic or Latino			Hispanic or Latino			Hispanic or Latino Origin Unknown			Total			
	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Total
Medicaid Only	1,115	841		43	28					1158	869	0	2027
Non-Medicaid Only	9,230	10084		437	624		109	157		9776	10865	0	20641
People Served by Both Medicaid and Non-Medicaid Sources	472	416		13	9		27	20		512	445	0	957
Medicaid Status Unknown	425	801		21	75		92	178		538	1054	0	1592
Total Served	11242	12142	0	514	736	0	228	355	0	11984	13233	0	25217
Comments on Data (for Age):													
Comments on Data (for Gender):													
Comments on Data (Overall):													

Each row should have a unique (unduplicated) count of clients: (1) Medicaid Only, (2) Non-Medicaid Only, (3) Both Medicaid and Other Sources funded their treatment, and (4) Medicaid Status Unknown).
If a state is unable to unduplicate between People whose care is paid by Medicaid, then they should report all data into the People Served by Both Medicaid and Other Sources and would check the box, People Served by Both is a duplicated count.

Table 6: Profile of Client Turnover

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 6.							
Report Year:	2005						
State Identifier:	NE						
	Total Served at Beginning of Year	Admissions During the year	Discharges During the year	Length of Stay (in Days): Discharged Patients		Average Length of Stay (in Days): Residents at end of year	
Profile of Service Utilization	(unduplicated)	(duplicated)	(duplicated)	Average (Mean)	Median	Average (Mean)	Median
State Hospitals	1,326	1,671	1,621				
Children (0 to 17 years)	141	165	144	87	60	104	82
Adults (18 yrs and over)	1,124	1,440	1,409	267	86	279	99
Age Not Available	61	66	68	85	86	86	90
Other Psychiatric Inpatient	3,092	3,246	2,324				
Children (0 to 17 years)	136	128	105	80	3	88	3
Adults (18 yrs and over)	2,928	3,074	2,193	129	11	250	21
Age Not Available	28	44	26	15	266	17	3
Residential Tx Centers	-	-	-				
Children (0 to 17 years)							
Community Programs	23,891	20,346					
Children (0 to 17 years)	2,541	1,417					
Adults (18 yrs and over)	20,957	18,648					
Age Not Available	393	281					
Comments on Data (State Hospital):							
Comments on Data (Other Inpatient):							
Comments on Data (Residential Treatment):							
Comments on Data (Community Programs):							
Comments on Data (Overall):							

Table 7. Profile of Mental Health Service Expenditures and Sources of Funding

This table describes expenditures for public mental health services provided or funded by the State mental health agency by source of funding.

This Table will be completed by the NASMHPD Research Institute (NRI) using data from the FY 2004 SMHA-Controlled Revenues and Expenditures Study

Table 7.				
Report Year:				
State Identifier:				
	State Hospital	**Other 24 Hour Care***	**Ambulatory/ Community Non-24 Hour Care**	**Total**
Total	**Data will come from the NRI's FY'2004 SMHA Revenues and Expenditures Study.**			
Medicaid				
Community MH Block Grant				
Other CMHS				
Other Federal (non-CMHS)				
State				
Other				

** Other 24 Hour Care: is "residential care" from both state hospitals and community ("Ambulatory/Community). Thus, "Other 24 Hour Care" expenditures are also included in the state hospital and/or "Ambulatory/Community" Columns as applicable.*

Comments on Data:

Note: The data in this table are derived from the National Association of State Mental Health Program Directors Research Institute, Inc's State Mental Health Agency-Controlled Revenues and Expenditures Study. FY 2004 Data for this table is currently being compiled by the NRI.

Table 8. Profile of Community Mental Health Block Grant Expenditures For Non-Direct Service Activities

This table is used to describe the use of CMHS BG funds for non-direct service activities that are sponsored, or conducted by the State Mental Health Authority

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 8	
Report Year:	2005
State Identifier:	NE
Profile of Community Mental Health Block Grant Expenditures for Non-Direct Service Activities	
Service	**Estimated Total Block Grant**
MHA Technical Assistance Activities	
MHA Planning Council Activities	
MHA Administration	
MHA Data Collection/Reporting	
MHA Activities Other Than Those Above	$104,308
Total Non-Direct Services	**$104,308**
Comments on Data:	The funds for State Administration (5% of total funds $2,086,159 equals $104,308) is used for Consumer Empowerment.

Table 9. Public Mental Health System Service Inventory Checklist

Table Deleted By CMHS

Table 10. Profile of Agencies Receiving Block Grant Funds Directly from the State MHA

This table is to be used to provide an inventory of providers/agencies who directly receive Block Grant allocations. Only report those programs that receive MHBG funds to provide services. Do not report planning council member reimbursements or other administrative reimbursements related to running the MHBG Program.
One row for each program

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 10				
Report Year:	2005			
State Identifier:	NE			
Agency Name	**Address**	**Name of Director**	**Phone #**	**Amount of Block Grant Allocation to Agency**
Region I Mental Health and Substance Abuse Administration	4110 Avenue D Scottsbluff, NE 69361	Sharyn Wohlers	308-635-3171	$186,251
Region II Human Services	110 North Bailey Street PO Box 1208 North Platte, NE 69103	Larry Brown	308-534-0440	$187,795
Region III Behavioral Health Services	4009 6th Avenue, Suite 65 PO Box 2555 Kearney, NE 68848	Beth Baxter	308-237-5113	$268,202
Region IV Behavioral Health Systems	206 Monroe Avenue Norfolk, NE 68701	Jean Sturtevant	402-370-3100	$272,545
Region V Systems	1645 "N" Street Suite A Lincoln, NE 68508	CJ Johnson	402-441-4343	$438,759
Region 6 Behavioral Healthcare	3801 Harney Street Omaha, NE 68131-3811	Patricia E. Jurjevich	402-444-6573	$583,226
State Administration (5%) for Consumer Empowerment				$104,308
Peer Review				$5,000
Rural Equity				$40,073
total				$2,086,159

*** If you need more lines for additional agencies, please add rows or make copies of this table.**

Table 11: Summary Profile of Client Evaluation of Care

Table 11.			
Report Year (Year Survey was Conducted): 2005			
State Identifier: NE			
Adult Consumer Survey Results:	**Number of Positive Responses**	**Responses**	**Confidence Interval***
1. Percent Reporting Positively About Access.	569	742	3.31
2. Percent Reporting Positively About Quality and Appropriateness for Adults.	598	730	3.34
3. Percent Reporting Positively About Outcomes.	513	732	3.34
4. Percent of Adults Reporting on Participation In Treatment Planning.	486	711	3.39
5. Percent of Adults Positively about General Satisfaction with Services.	594	747	3.30
Child/Adolsecent Consumer Survey Results:	**Number of Positive Responses**	**Responses**	**Confidence Interval***
1. Percent Reporting Positively About Access.	176	233	5.36
2.Percent Reporting Positively about General Satisfaction for Children.	166	233	5.36
3.Percent Reporting Positively about Outcomes for Children.	138	226	5.48
4. Percent of Family Members Reporting on Participation In Treatment Planning for their Children.	172	232	5.38
5. Percent of Family Members Reporting High Cultural Sensitivity of Staff. (Optional)	202	223	5.53

Comments on Data:

Adult Consumer Surveys

1. Was the Official 28 Item MHSIP Adult Outpatient Consumer Survey Used? ☑ Yes ☐ No

1.a. If no, which version:
- 1. Original 40 Item Version ☐ Yes
- 2. 21-Item Version ☐ Yes
- 3. State Variation of MHSIP ☐ Yes
- 4. Other Consumer Survey ☐ Yes

1.b. If other, please attach instrument used.

1.c. Did you use any translations of the MHSIP into another language? ☐ 1. Spanish

2. Other Language:

Adult Survey Approach:

2. Populations covered in survey? (Note all surveys should cover all regions of state)
- ☐ 1. All Consumers in State
- ☑ 2. Sample of MH Consumers

2.a. If a sample was used, what sample methodology was used?
- ☑ 1. Random Sample
- ☐ 2. Stratified Sample
- ☐ 3. Convenience Sample

4. Other Sample:

2.b Do you survey only people currently in services, or do you also Survey Persons no longer in service?

- [x] 1. Persons Currently Receiving Services
- [x] 2. Persons No Longer Receiving Services

3. Please Describe the populations included in your sample: (e.g., all adults, only adults with SMI, etc.)

- [x] 1. All Adult consumers in state
- [ ] 2. Adults with Serious Mental Illness
- [ ] 3. Adults who were Medicaid Eligible or in Medicaid Managed Care

3.4 Other: describe: (for example, if you survey anyone served in the last 3 months, describe that here):

4. Methodology of collecting data? (Check all that apply)

	Self-Administered	Interview
Phone	☐ Yes ☐ Yes	☑ Yes
Mail	Yes	
Face-to-face		☐ Yes
Web-Based	☐ Yes	☐ Yes

4.b. Who administered the Survey? (Check all that apply)

- [x] 1. MH Consumers
- [ ] 2. Family Members
- [x] 3. Professional Interviewers
- [ ] 4. MH Clinicians
- [ ] 5. Non Direct Treatment Staff

6. Other: describe:

5. Are Responses Anonymous, Confidential and/or Linked to other Patient Databases?

- [x] 1. Responses are Anonymous
- [x] 2. Responses are Confidential
- [ ] 3. Responses are Matched to Client databases

6. Sample Size and Response Rate

6a. How many Surveys were Attempted (sent out or calls initiated)?	
6.b How many survey Contacts were made? (surveys to valid phone numbers or addresses)	
6.c How many surveys were completed? (survey forms returned or calls completed)	749
6.d. What was your response rate? (number of Completed surveys divided by number of Contacts)	

6.e. If you receive "blank" surveys back from consumers (surveys with no responses on them), did you count these survey's as "completed" for the calculation of response rates? ☐ Yes ☑ No

7. Who Conducted the Survey

7.a. SMHA Conducted or contracted for the Survey (survey done at state level)	☑ Yes ☐ No
7.b. Local Mental Health Providers/County mental heatlh providers conducted or contracted for the survey (survey was done at the local or regional level)	☐ Yes ☑ No

7.c. Other: Describe:

* Report Confidence Intervals at the 95% confidence level

Note: The confidence interval is the plus-or-minus figure usually reported in newspaper or television opinion poll results. For example, if you use a confidence interval of 4 and 47% percent of your sample picks an answer you can be "sure" that if you had asked the question of the entire relevant population between 43% (47-4) and 51% (47+4) would have picked that answer.

The confidence level tells you how sure you can be. It is expressed as a percentage and represents how often the true percentage of the population who would pick an answer lies within the confidence interval. The 95% confidence level means you can be 95% certain; the 99% confidence level means you can be 99% certain. Most researchers use the 95% confidence level.

When you put the confidence level and the confidence interval together, you can say that you are 95% sure that the true percentage of the population is between 43% and 51%. (From www.surveysystem.com)

Child/Family Consumer Surveys

1. Was the MHSIP Children/Family Survey (YSS-F) Used? ☑ Yes ☐ No
If no, please attach instrument used.

1.c. Did you use any translations of the Child MHSIP into another language? ☐ 1. Spanish
2. Other Language:

Child Survey Approach:

2. Populations covered in survey? (Note all surveys should cover all regions of state) ☐ 1. All Consumers in State ☐ 2. Sample of MH Consumers

2.a. If a sample was used, what sample methodology was used? ☑ 1. Random Sample ☐ 2. Stratified Sample ☐ 3. Convenience Sample
4. Other Sample:

2.b Do you survey only people currently in services, or do you also Survey Persons no longer in service?
☑ 1. Persons Currently Receiving Services
☑ 2. Persons No Longer Receiving Services

2a. If yes to 2, please describe how your survey persons no longer receiving services.

3. Please Describe the populations included in your sample: (e.g., all children, only chidlren with SED, etc.)
☑ 1. All Child consumers in state
☐ 2. Children with Serious Emotional Disturbances
☐ 3. Children who were Medicaid Eligible or in Medicaid Managed Care

3.4 Other: describe: (for example, if you survey anyone served in the last 3 months, describe that here):

4. Methodology of collecting data? (Check all that apply)

	Self-Administered	Interview
Phone	☐ Yes	☑ Yes
Mail	☑ Yes	
Face-to-face		☐ Yes
Web-based	☐ Yes	☐ Yes

4.b. Who administered the Survey? (Check all that apply)
☑ 1. MH Consumers
☐ 2. Family Members
☑ 3. Professional Interviewers
☐ 4. MH Clinicians
☐ 5. Non Direct Treatment Staff
6. Other: describe:

5. Are Responses Anonymous, Confidential and/or Linked to other Patient Databases?
☑ 1. Responses are Anonymous
☑ 2. Responses are Confidential
☐ 3. Responses are Matched to Client databases

6. Sample Size and Response Rate

6a. How many Surveys were Attempted (sent out or calls initiated)?	
6.b How many survey Contacts were made? (surveys to valid phone numbers or addresses)	
6.c How many surveys were completed? (survey forms returned or calls completed)	235
6.d. What was your response rate? (number of Completed surveys divided by number of Contacts)	

6.e. If you receive "blank" surveys back from consumers (surveys with no responses on them), did you count these survey's as "completed" for the calculation of response rates? ☐ Yes ☑ No

7. Who Conducted the Survey
7.a. SMHA Conducted or contracted for the Survey (survey done at state level) ☑ Yes ☐ No
7.b. Local Mental Health Providers/County mental heatlh providers conducted or contracted for the survey ☐ Yes ☐ No

(survey was done at the local or regional level) ☐ Yes ☐ No

7.c. Other: Describe:

Table 11a: Consumer Evaluation of Care by Consumer Characteristics: (Optional Table by Race/Ethnicity.)

Table 11.																		
Report Year: 2005																		
State Identifier:NE																		
Indicators	**Total**		**American Indian or Alaska Native**		**Asian**		**Black or African American**		**Native Hawaiian or Other Pacific Islander**		**White**		**More than One Race Reported**		**Other/ Unknown**		**Hispanic**	
Adult Consumer Survey Results:	**# Positive**	**Responses**	**# Positive**	**Responses**	**# Positive**	**Responses**	**# Positive**	**Responses**	**# Positive**	**Responses**	**# Positive**	**Responses**	**# Positive**	**Responses**	**# Positive**	**Responses**	**# Positive**	**Responses**
Percent Reporting Positively About Access.			13	19	3	4	31	40	2	2	485	621	8	12	27	44	30	41
Percent Reporting Positively About Quality and Appropriateness.			12	19	4	4	29	37	1	2	513	612	9	12	30	44	31	41
Percent Reporting Positively About Outcomes.			11	19	2	4	31	39	2	2	439	614	5	12	23	42	29	41
Percent Reporting Positively about Participation in Treatment Planning			11	17	2	4	27	36	1	1	419	600	7	12	19	41	22	40
Percent Reporting Positively about General Satisfaction			12	18	4	4	31	43	2	2	508	624	8	12	29	44	33	41
Child/Adolescent Consumer Survey Results:	**# Positive**	**Responses**	**# Positive**	**Responses**	**# Positive**	**Responses**	**# Positive**	**Responses**	**# Positive**	**Responses**	**# Positive**	**Responses**	**# Positive**	**Responses**	**# Positive**	**Responses**	**# Positive**	**Responses**
Percent Reporting Positively About Access.			1	1	0	0	10	12	1	1	150	200	4	7	10	12	12	15
Percent Reporting Positively About General Satisfaction			1	1	0	0	9	12	1	1	143	200	3	7	9	12	11	15
Percent Reporting Positively About Outcomes.			1	1	0	0	8	12	1	1	119	193	2	7	7	12	8	15
Percent Reporting Positively about Participation in Treatment Planning for their Children.			1	1	0	0	9	12	1	1	146	199	5	7	10	12	11	15
Percent Reporting Positively About Cultural Sensitivity of Staff.			1	1	0	0	9	12	1	1	174	190	6	7	11	12	13	15

Comments on Data:

Table 11B. Survey Responses by Hispanic/Latino Origin

Table 11b.													
Report Year: 2005													
State Identifier: NE													
	Not Hispanic or Latino			Hispanic or Latino			Hispanic or Latino Origin Not Available			Total			
Adult Consumer Survey Results:	**Female**	**Male**	**NA**	**Female**	**Male**	**NA**	**Female**	**Male**	**NA**	**Female**	**Male**	**NA**	**Total**
# Reporting Positively About Access	288	247	0	12	18	0	1	3	0				
# Reporting Positively About Quality and Appropriateness	295	269	0	12	19	0	1	2	0				
# Reporting Positively About Outcomes	251	231	0	12	17	0	1	1	0				
# Reporting Positively About Treatment Planning	239	223	0	10	12	0	1	1	0				
# Reporting Positively About General Satisfaction	300	257	0	14	19	0	1	3	0				

	Not Hispanic or Latino			Hispanic or Latino			Hispanic or Latino Origin Not Available			Total			
Family Survey Results:	**Female**	**Male**	**NA**	**Female**	**Male**	**NA**	**Female**	**Male**	**NA**	**Female**	**Male**	**NA**	**Total**
# Reporting Positively About Access	129	35	0	9	3	0	2	0	0				
# Reporting Positively About General Satisfaction	122	33	0	8	3	0	0	0	0				
# Reporting Positively About Outcomes	100	30	0	5	3	0	0	0	0				
# Reporting Positively About Participation in Treatment Planning for their Children	127	34	0	9	2	0	0	0	0				
# Reporting Positively About Cultural Sensitivity of Staff	151	38	0	10	3	0	0	0	0				

Table 12: State Mental Health Agency Profile

The purpose of this profile is to obtain information that provides a context for the data provided in the tables. This profile covers the populations served, services for which the state mental health agency is responsible, data reporting capacities, especially related to duplication of numbers served as well as certain summary administrative information.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 12	
Report Year:	***2005***
State Identifier:	***NE***

Populations Served

1 Which of the following populations receive services operated or funded by the state mental health agency? Please indicate if they are included in the data provided in the tables. (Check all that apply.)

	Populations Covered		Included in Data	
	State Hospitals	Community Programs	State Hospitals	Community Programs
1. Aged 0 to 3	☐ Yes	☑ Yes	☐ Yes	☑ Yes
2. Aged 4 to 17	☑ Yes	☑ Yes	☑ Yes	☑ Yes
3. Adults Aged 18 and over	☑ Yes	☑ Yes	☑ Yes	☑ Yes
4. Forensics	☑ Yes	☐ Yes	☑ Yes	☐ Yes
Comments on Data:				

2 Do all of the adults and children served through the state mental health agency meet the Federal definitions of serious mental illness and serious emotional disturbances?

no ☐ Serious Mental Illness

no ☐ Serious Emotional Disturbances

2.a. If no, please indicate the percentage of persons served for the reporting period who met the federal definitions of serious mental illness and serious emotional disturbance?

2.a.1	Percent of adults meeting Federal definition of SMI:	74.3%
2.a.2	Percentage of children/adolescents meeting Federal definition of SED	94.4%

3 Co-Occurring Mental Health and Substance Abuse:

3.a. What percentage of persons served by the SMHA for the reporting period have a dual diagnosis of mental illness and substance abuse?

3.a.1	Percentage of adults served by the SMHA who also have a diagnosis of substance abuse problem:	2,080 (9.13%)
3.a.2.	Percentage of children/adolescents served by the SMHA who also have a diagnosis of substance abuse problem:	98 (4.01%)

3.b. What percentage of persons served for the reporting period who met the Federal definitions of adults with SMI and children/adolescents with SED have a dual diagnosis of mental illness and substance abuse.

3.b.1	Percentage of adults meeting Federal definition of SMI who also have a diagnosis of substance abuse problem:	1995 (11.79%)
3.b.2.	Percentage of children/adolescents meeting the Federal definition of SED who also have a diagnosis of substance abuse problem:	98 (4.25%)

3b.3	Please describe how you calculate and count the number of persons with co-occurring disorders	1) Persons met the Axis 1 code criteria for Mental Illness and Substance abuse 2) Persons met the Service Authorization/CPT Codes criteria for Both Mental Illness and Substance 3) Persons had as "Reason for Admission" a combination of Dual Diagnosises e.g. Primary Mental Illness/ Secondary Substance Abuse.

4 State Mental Health Agency Responsibilities

a. Medicaid: Does the State Mental Health Agency have any of the following responsibilities for mental health services provided through Medicaid? (Check All that Apply)

1. State Medicaid Operating Agency	☐
2. Setting Standards	☐
3. Quality Improvement/Program Compliance	☐
4. Resolving Consumer Complaints	☐
5. Licensing	☐
6. Sanctions	☐
7. Other	

	b. Managed Care (Mental Health Managed Care		Are Data for these programs reported on URS Tables?
4.b.1	Does the State have a Medicaid Managed Care initiative?	☑ Yes	☐ Yes
4.b.2	Does the State Mental Health Agency have any responsibilities for mental health services provided through Medicaid Managed Care?	☐ Yes	☐ Yes
	If yes, please check the responsibilities the SMHA has:		
4.b.3	Direct contractual responsibility and oversight of the MCOs or BHOs	☐ Yes	
4.b.4	Setting Standards for mental health services	☐ Yes	
4.b.5	Coordination with state health and Medicaid agencies	☐ Yes	
4.b.6	Resolving mental health consumer complaints	☐ Yes	
4.b.7	Input in contract development	☐ Yes	
4.b.8	Performance monitoring	☐ Yes	
4.b.9	Other		

5 Data Reporting: Please describe the extent to which your information systems allows the generation of unduplicated client counts between different parts of your mental health system. Please respond in particular for Table 2, which requires unduplicated counts of clients served across your entire mental health system.

Are the data reporting in the tables?

5.a.	**Unduplicated** :counted once even if they were served in both State hospitals and community programs and if they were served in community mental health agencies responsible for different geographic or programmatic areas.	☑
5.b.	**Duplicated:** across state hospital and community programs	☐
5.c.	**Duplicated:** within community programs	☐
5.d.	**Duplicated:** Between Child and Adult Agencies	☐

5.e. **Plans for Unduplication:** If you are not currently able to provide unduplicated client counts across all parts of your mental health system, please describe your plans to get unduplicated client counts by the end of your Data Infrastructure Grant.

6 Summary Administrative Data

6.a.	Report Year	2005		
6.b.	State Identifier	NE		
	Summary Information on Data Submitted by SMHA:			
6.c.	Year being reported: From:	01-Jul-04	to	30-Jun-05
6.d.	Person Responsible for Submission	Jim Harvey		
6.e.	Contact Phone Number:	402-479-5125		
6.f.	Contact Address	Nebraska Division of Behavioral Health Services		
		P.O. Box 98925; Lincoln, NE 68509-8925		
6.g.	E-mail:	jim.harvey@hhss.ne.gov		

Extra Table: General/Additional Footnotes

Please use this table to enter any general comments and/or additional footnotes. This can be used for both footnotes that did not fit in the Footnotes field for a certain table ,or it can be used for comments that apply to several tables, or are general comments for a state.

Comment No.	Re. Table No.	Comment
	Table 8	The funds for State Administration (5% of total funds $2,086,159 equals $104,308) is used for Consumer Empowerment. For more information, see Nebraska Community Mental Health Services Block Grant Application for FY 2006; Adult Goal #2: Empower Consumers (pages 49-51). Table 8 is the "Profile of Community Mental Health Block Grant Expenditures For Non-Direct Service Activities"

Table 14A. Profile of Persons with SMI/SED served by Age, Gender and Race/Ethnicity

This is a developmental table similar to Table 2A. and 2B. This table requests counts for persons with SMI or SED using the definitions provided by the CMHS. Table 2A. and 2B. included all clients served by publicly operated or funded programs. This table counts only clients who meet the CMHS definition of SMI or SED. For many states, this table may be the same as Tables 2A. and 2B. For 2003, states should report using the Federal Definitions of SMI and SED if they can report them, if not, please report using your state's definitions of SMI and SED and provide information below describing your state's definition.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Please enter the "total" in the appropriate row and column and report the data under the categories listed.

Table 14A.																
Report Year:	2005															
State Identifier:	NE															
	Total				American Indian or Alaska Native			Asian			Black or African American			Native Hawaiian Pacific Isla	
	Female	Male	Not Available	Total	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male
0-3 Years	43	41	0	84	1	1					5	6			
4-12 years	341	626	0	967	4	47		8	2		30	63			1
13-17 years	535	715	0	1250	25	38		5	5		30	54		1	3
18-20 years	265	380	0	645	5	17		2			23	25			
21-64 years	7264	7607	0	14871	224	269		34	49		569	728		2	4
65-74 years	208	103	0	311	3	6		3			8	3			
75+ years	116	60	0	176	2	1		1							
Not Available	389	522	0	911	14	32		3	5		15	51			
Total	9161	10054	0	19215	278	411	0	56	61	0	680	930	0	3	8
Comments on Data (for Age):															
Comments on Data (for Gender):															
Comments on Data (for Race/Ethnicity):															
Comments on Data (Overall):															

1. State Definitions Match the Federal Definitions:

☐ Yes ☐ No Adults with SMI, if No describe or attach state definition: _____

Diagnoses included in state SMI definition: _____

☐ Yes ☐ No Children with SED, if No describe or attach state definition: _____

Diagnoses included in state SED definition: _____

Table 14A. Profil

This is a developn
CMHS. Table 2A.
definition of SMI o
Definitions of SMI
describing your st

PLEASE DO

Please enter the "

Table 14A.	
Report Year:	
State Identifier:	
	or Other nder
	Not Available
0-3 Years	
4-12 years	
13-17 years	
18-20 years	
21-64 years	
65-74 years	
75+ years	
Not Available	
Total	0
Comments on Data (for Age):	
Comments on Data (for Gender):	
Comments on Data (for Race/Ethnicity):	
Comments on Data (Overall):	

1. State Definitions I

☐ Yes ☐ No

☐ Yes ☐ No

Table 14A. Profil

This is a developn
CMHS. Table 2A.
definition of SMI o
Definitions of SMI
describing your st

PLEASE DO

Please enter the "

Table 14A.	
Report Year:	
State Identifier:	

	White			Hispanic **use only if data for Table 14b are not available*			More Than One Race Reported			Race Not Available		
	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available
0-3 Years	35	27								2	7	
4-12 years	280	475								19	38	
13-17 years	433	557					1	9		40	49	
18-20 years	217	301					1	1		17	36	
21-64 years	6,035	5,952					5	8		395	597	
65-74 years	179	85								15	9	
75+ years	105	55								8	4	
Not Available	335	384						4		22	46	
Total	7619	7836	0	0	0	0	7	22	0	518	786	0

Comments on Data (for Age):	
Comments on Data (for Gender):	
Comments on Data (for Race/Ethnicity):	
Comments on Data (Overall):	

1. State Definitions I

☐ Yes ☐ No

☐ Yes ☐ No

Table 14B. Profile of Persons with SMI/SED served by Age, Gender and Race/Ethnicity

Of the total persons served, please indicate the age, gender and the number of persons who meet the Federal definition of SMI and SED and who are Hispanic/Latino or not Hispanic/Latino. The total persons served who meet the Federal definition of SMI or SED should be the total as indicated in Table 14A.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Please enter the "total" in the appropriate row and column and report the data under the categories listed.

Table 14B.													
Report Year:	2005												
State Identifier:	NE												
	Not Hispanic or Latino			Hispanic or Latino			Hispanic or Latino Origin Not Available			Total			
	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Total
0 - 3 Years	39	35		2	6		2			43	41	0	84
4 - 12 years	316	574		24	49		1	3		341	626	0	967
13 - 17 years	491	654		39	49		5	12		535	715	0	1250
18 - 20 years	250	348		15	25			7		265	380	0	645
21-64 years	6821	6977		293	383		150	247		7264	7607	0	14871
65-74 years	198	94		6	5		4	4		208	103	0	311
75+ years	106	56		4			6	4		116	60	0	176
Not Available	363	467		18	36		8	19		389	522	0	911
Total	8584	9205	0	401	553	0	176	296	0	9161	10054	0	19215
Comments on Data (for Age):													
Comments on Data (for Gender):													
Comments on Data (for Race/Ethnicity):													

Table 15. Living Situation Profile:

Number of Clients in Each Living Situation as Collected by the Most Recent Assessment in the Reporting Period
All Mental Health Programs by Age, Gender, and Race/Ethnicity

Please provide unduplicated counts, if possible. This table provides an aggregate profile of persons served in the reporting year. The reporting year should be the latest state fiscal year for which data are available. This profile is based on a client

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Please enter the "total" for the appropriate row and column and report the data under the Living Situation categories listed.

Table 15.											
Report Year:	2005										
State Identifier:	NE										
	Private Residence	**Foster Home**	**Residential Care**	**Crisis Residence**	**Children's Residential Treatment**	**Institutional Setting**	**Jail/ Correctional Facility**	**Homeless/ Shelter**	**Other**	**NA**	**Total**
0-17	2399	52	24		17	136	12	13	22	7	2682
18-64	16742	27	821		7	1569	405	770	780	219	21340
65 +	441	4	109			59	2	7	10	22	654
Not Available	419	16	13		7	68	3	7	5	3	541
TOTAL	20001	99	967	0	31	1832	422	797	817	251	25217
Female	9912	36	468		17	594	98	367	382	110	11984
Male	10089	63	499		14	1238	324	430	435	141	13233
Not Available											0
TOTAL	20001	99	967	0	31	1832	422	797	817	251	25217
American Indian/Alaska Native	740	8	42		2	43	16	21	18	1	891
Asian	118	2	4			18	4	2	4	2	154
Black/African American	1442	9	75		3	237	77	127	107	12	2089
Hawaiian/Pacific Islander	9					1		1	1		12
White/Caucasian	16709	72	809		17	1154	296	611	626	151	20445
Hispanic *											0
More than One Race Reported					3	26					29
Race/Ethnicity Not Available	983	8	37		6	353	29	35	61	85	1597
TOTAL	20001	99	967	0	31	1832	422	797	817	251	25217
Hispanic or Latino Origin	1026	6	22		3	82	30	30	45	6	1250
Non Hispanic or Latino Origin	18741	92	918		25	1490	383	759	772	204	23384
Hispanic or Latino Origin Not Available	234	1	27		3	260	9	8		41	583
TOTAL	20001	99	967	0	31	1832	422	797	817	251	25217
Comments on Data:											

How Often Does your State Measure Living Situation? ☑ At Admission ☑ At Discharge ☐ Monthly ☐ Quarterly ☐ Other: describe: _____

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethinic Origin are not available

TABLE 16: DEFINITIONS AND INSTRUCTIONS

DEFINITIONS

Supported Housing:

Services to assist individuals in finding and maintaining appropriate housing arrangements. This activity is premised upon the idea that certain clients are able to live independently in the community only if they have support staff for monitoring and/or assisting with residential responsibilities. These staff assist clients to select, obtain, and maintain safe, decent, affordable housing and maintain a link to other essential services provided within the community. The objective of supported housing is to help obtain and maintain an independent living situation.

Supported Housing is a specific program model in which a consumer lives in a house, apartment or similar setting, alone or with others, and has considerable responsibility for residential maintenance but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities, criteria identified for supported housing programs include: housing choice, functional separation of housing from service provision, affordability, integration (with persons who do not have mental illness), right to tenure, service choice, service individualization and service availability.

Supported Employment:

Mental Health Supported Employment (SE) is an evidence-based service to promote rehabilitation and return to productive employment for persons with serious mental illness' rehabilitation and their return to productive employment. SE programs use a team approach for treatment, with employment specialists responsible for carrying out all vocational services from intake through follow-along. Job placements are: community-based (i.e., not sheltered workshops, not onsite at SE or other treatment agency offices), competitive (i.e., jobs are not exclusively reserved for SE clients, but open to public), in normalized settings, and utilize multiple employers. The SE team has a small client:staff ratio. SE contacts occur in the home, at the job site, or in the community. The SE team is assertive in engaging and retaining clients in treatment, especially utilizing face-to-face community visits, rather than phone or mail contacts. The SE team consults/works with family and significant others when appropriate. SE services are frequently coordinated with Vocational Rehabilitation benefits.

Assertive Community Treatment:

A team based approach to the provision of treatment, rehabilitation and support services. ACT/PACT models of treatment are built around a self-contained multi-disciplinary team that serves as the fixed point of responsibility for all patient care for a fixed group of clients. In this approach, normally used with clients with severe and persistent mental illness, the treatment team typically provides all client services using a highly integrated approach to care. A key aspect are low caseloads and the availability of the services in a range of settings. The service is a recommended practice in the PORT study (Translating Research Into Practice: The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations, Lehman, Steinwachs and Co-Investigators of Patient Outcomes Research Team, Schizophrenia Bulletin, 24(1):1-10, 1998) and is cited as a practice with strong evidence based on controlled, randomizaed effectiveness studies in the Surgeon General's report on mental health (Mental Health: A Report of the Surgeon General, December, 1999, Chapter 4, "Adults and Mental Health, Service Delivery, Assertive Community Treatment"). Additionally, HCFA recommended that state Medicaid agencies consider adding the service to their State Plans in HCFA Letter to State Medicaid Directors, Center for Medicaid and State Operations , June 07, 1999.

Therapeutic Foster Care:

Children are placed with foster parents who are trained to work with children with special needs. Usually, each foster home takes one child at a time, and caseloads of supervisors in agencies overseeing the program remain small. In

addition, therapeutic foster parents are given a higher stipend than to traditional foster parents, and they receive extensive pre-service training and in-service supervision and support. Frequent contact between case managers or care coordinators and the treatment family is expected, and additional resources and traditional mental health services may be provided as needed."

Multisystemic Therapy (MST)

MST views the individual as nestled within a complex network of interconnected systems (family, school, peers). The goal is to facilitate change in this natural environment to promote individual change. The caregiver is viewed as the key to long-term outcomes

Functional Family Therapy (FFT)

A phasic program where each step builds on one another to enhance protective factors and reduce risk by working with both the youth the their family. The phases are engagement, motivation, assessment, behavior change, and generalization

INSTRUCTIONS

1 Please enter the unduplicated number of adults with serious mental illness and children with serious emotional disturbances who received each service category during the reporting year.

2 Please enter the unduplicated number of adults with serious mental illness and children with SED served in each of the age, sex and race/ethnicity categories during the reporting period.

3 States are using a variety of instruments to monitor fidelity, some of which are more standardized than others. If fidelity is being monitored in your state, please indicate the instrument being used for each service category.

Table 16: Profile of Adults with Serious Mental Illnesses and Children with Serious Emotional Disturbances Receiving Specific Services:

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 16.								
Report Year:	2005							
State Identifier:	NE							
	Adults with Serious Mental Illness (SMI)				Children with Serious Emotional Distrubance (SED)			
	n Receiving Supported Housing	n Receiving Supported Employment	n Receiving Assertive Community Treatment	Total unduplicated N - Adults with SMI served	n Receiving Thereaputic Foster Care	n Receiving Multi-Systemic Therapy	n Receiving Family Functional Therapy	Total unduplicated N - Children with SED
Age						Provisional Pending Review by OMB: Please Report if Possible		
0-3								
4-12								
13-17								
18-20								
21-64								
65-74								
75+								
Not Available								
TOTAL	0	0	0	0	0	0	0	0
Gender								
Female								
Male								
Not Available								
Race/Ethnicity								
American Indian/Alaska Native								
Asian								
Black/African American								
Hawaiian/Pacific Islander								
White								
Hispanic*								
More than one race								
Not Available								
Hispanic/Latino Origin								
Hispanic/Latino Origin								
Non Hispanic/Latino								
Not Available								
Do You monitor fidelity for this service?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
IF YES,								
What fidelity measure do you use?								
Who measures fidelity?								
How often is fidelity measured?								

* Hispanic is part of the total served. ○ Yes ○ No

Comments on Data:	

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethinic Origin are not available

TABLE 17: DEFINITIONS AND INSTRUCTIONS

DEFINITIONS

Family Psychoeducation:

Offered as part of an overall clinical treatment plan for individuals with mental illness to achieve the best possible outcome through the active involvement of family members in treatment and management and to alleviate the suffering of family members by supporting them in their efforts to aid the recovery of their loved ones. Family Psychoeducation programs may be either multi-family or single-family focused. Core characteristics of family Psychoeducation programs include the provision of emotional support, education, resources during periods of crisis, and problem-solving skills.

Integrated Treatment for Co-occurring Disorders

Dual diagnosis treatments combine or integrate mental health and substance abuse interventions at the level of the clinical encounter. Hence, integrated treatment means that the same clinicians or teams of clinicians, working in one setting, provide appropriate mental health and substance abuse interventions in a coordinated fashion. In other words, the caregivers take responsibility for combining the interventions into one coherent package. For the individual with a dual diagnosis, the services appear seamless, with a consistent approach, philosophy, and set of recommendations. The need to negotiate with separate clinical teams, programs, or systems disappears. The goal of dual diagnosis interventions is recovery from two serious illnesses.

Illness Self-Management

Illness Self-Management (also called illness management or wellness management): Is a broad set of rehabilitation methods aimed at teaching individuals with a mental illness strategies for collaborating actively in their treatment with professionals, for reducing their risk of relapses and rehospitalizations, for reducing severity and distress related to symptoms, and for improving their social support. Specific evidence-based practices that are incorporated under the broad rubric of illness self-management are psychoeducation about the nature of mental illness and its treatment, "behavioral tailoring" to help individuals incorporate the taking of medication into their daily routines, relapse prevention planning, teaching coping strategies to managing distressing persistent symptoms, cognitive-behavior therapy for psychosis, and social skills training. The goal of illness self-management is to help individuals develop effective strategies for managing their illness in collaboration with professionals and significant others, thereby freeing up their time to pursue their personal recovery goals.

Medication Management

In the toolkit on medication management there does not appear to be any explicit definition of medication management. However the critical elements identified for evidence-based medication management approaches are the following:

1. Utilization of a systematic plan for medication management
2. Objective measures of outcome are produced
3. Documentation is thorough and clear
4. Consumers and practitioners share in the decision-making

INSTRUCTIONS

1 Please enter the unduplicated number of adults with serious mental illness who received each service category during the reporting year.

2 Please enter the unduplicated number of adults with serious mental illness (or children with SED) in each age, sex and race/ethnicity category that received any service during the year.

3 States are using a variety of instruments to monitor fidelity, some of which are more standardized than others. If fidelity is being monitored in your state, pleas indicate the instrument being used for each service category.

Table 17: Profile of Adults with Serious Mental Illnesses Receiving Specific Services During The Year:

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 17.				
Report Year:	**2005**			
State Identifier:	NE			
	ADULTS WITH SERIOUS MENTAL ILLNESS			
	Receiving Family Psychoeducation	Receiving Integrated Treatment for Co-occurring Disorders (MH/SA)	Receiving Illness Self Management	Receiving Medication Management
Age				Provisional Pending Review by OMB: Please Report if Possible
18-20		17		
21-64		869		
65-74		19		
75+		2		
Not Available		25		
TOTAL	0	932	0	0
Gender				
Female		468		
Male		464		
Not Available				
Race				
American Indian/ Alaska Native		13		
Asian		5		
Black/African American		131		
Hawaiian/Pacific Islander		2		
White		748		
Hispanic*				
More than one race				
Unknown		33		
Hispanic/Latino Origin				
Hispanic/Latino Origin		25		
Non Hispanic/Latino		907		
Hispanic origin not available				

Do You monitor fidelity for this service?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
IF YES,								
What fidelity measure do you use?								
Who measures fidelity?								
How often is fidelity measured?								

* Hispanic is part of the total served. ○ Yes ◉ No

Comments on Data:	

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethinic Origin are not available

Table 18: Profile of Adults with Schizophrenia Receiving New Generation Medications During The Year

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 18.						
Report Year:						
State Identifier:						
	STATE HOSPITALS		**COMMUNITY SETTINGS**		**STATE MENTAL HEALTH SYSTEM**	
	Unduplicated N of Adults with Schizophrenia Receiving New Generation Meds	Unduplicated N of Adult with Schizophrenia Served	Unduplicated N of Adults with Schizophrenia Receiving New Generation Meds	Unduplicated N of Adult with Schizophrenia Served	Unduplicated N of Adults with Schizophrenia Receiving New Generation Meds	Unduplicated N of Adult with Schizophrenia Served
Age						
18-20						
21-64						
65-74						
75+						
Not Available						
TOTAL	0	0	0	0	0	0
Gender						
Female						
Male						
Not Available						
Race						
American Indian/ Alaska Native						
Asian						
Black/African American						
Hawaiian/Pacific Islander						
White						
Hispanic*						
More than one race						
Unknown						
Hispanic/Latino Origin						
Hispanic/Latino Origin						
Non Hispanic/Latino						
Hispanic origin not available						
Are specific clinical guidelines followed?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
If Yes, which one?						

* Hispanic is part of the total served. ○ Yes ○ No

Comments on Data:	

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethinic Origin are not available

Table 19A. Profile of Adult Criminal Justice Involvement:

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

This is a developmental measure. To assist in the development process, we are asking states to report any information they can currently provide with their December 2003 MHBG submission. Use multiple tables, as described below, if needed.

Rates of criminal justice involvement for people who received mental health services may be reported for a variety of time periods. Generally, rates are computed for all individuals who were served during a selected year. These rates may describe criminal justice involvement during the same year as services were received, during the year before services were received, or during the year after services were received. Please specify the time period in which services were received (e.g., FY2002) and the time period(s) during which criminal justice involvement was measured. If data are available for more than one time period, please provide one table for each time period.

Two indicators of criminal justice involvement are suggested: arrest, and incarceration (in either local or state facilities). Please specify, on page 2, the measure you are reporting. If more than one measure is available for your state, please provide separate tables for each.

These data may be collected using at least three different sources of information: criminal justice records/databases, mental health management information systems, anc

Finally, data may be available for your entire state or for only some regions of the state. Please provide whatever data you have available and specify, on page 2, characte

Please tell us anything else that would help us to understand your indicator (eg., list survey or MIS questions; describe linking methodology and data sources; specify time period for criminal justice involvement; explain whether treatment data are collected at admission, update or discharge; or evaluate the quality of your data). If you are now

Table 19A. Profile of Adult Criminal Justice

State: _____ Time period in which services were received: _____

Title of indicator: _____

Mark the option you are reporting in this table: __ 1)Arrests __ 2)Prison incarceration __ 3)Jail incarceration __ 4)Other (specify)_____

Mental health programs include: __ 1)Adult with SMI only __ 2)Other adults (specify)_____ __ 3)Both.

Time period in which criminal justice contact was measured: _____

Source of criminal justice information: __ 1)State criminal justice agency __ 2)Local criminal justice agency __ 3)Mental health MIS
__ 4)Consumer survey __ 5) Other (specify)_____

Region for which data are reported: ___ 1)The whole state ___ 2)Less than the whole state (please describe) _____

	A. Total Number on Caseload	B. Number for Whom Data are Available	C. Number with Criminal Justice Involvement	D. Consumer Criminal Justice Involvement Rate (C/B)	E. Total State Population Criminal Justice Involvement Rate (if available)
Total	0	0	0	NA	0.00
Female				NA	
Male				NA	
Gender not available				NA	
0-17				NA	
18-34				NA	
35-49				NA	
50-64				NA	
65 +				NA	
Age not available				NA	
American Indian/ Alaska Native				NA	
Asian				NA	
Black/African American				NA	
Hawaiian/Pacific Islander				NA	
White				NA	
Hispanic*				NA	
More than one race				NA	
Race Not Available				NA	
Hispanic or Latino Origin				NA	
Non Hispanic or Latino Origin				NA	
Hispanic origin not available				NA	
Comments on Data:					

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethinic Origin are not available

Table 19B. Profile of Juvenile Justice Involvement:

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

This is a developmental measure. To assist in the development process, we are asking states to report any information they can currently provide with their December 2003 MHBG submission. Use multiple tables, as described below, if needed.

Rates of juvenile justice involvement for people who received mental health services may be reported for a variety of time periods. Generally, rates are computed for all individuals who were served during a selected year. These rates may describe juvenile justice involvement during the same year as services were received, during the year before services were received, or during the year after services were received. Please specify the time period in which services were received (e.g., FY2002) and the time period(s) during which juvenile justice involvement was measured. If data are available for more than one time period, please provide one table for each time period.

Two indicators of juvenile justice involvement are suggested: arrest, and incarceration (in either local or state facilities). Please specify, on page 2, the measure you are reporting. If more than one measure is available for your state, please provide separate tables for each.

These data may be collected using at least three different sources of information: juvenile justice records/databases, mental health management information systems, ar

Finally, data may be available for your entire state or for only some regions of the state. Please provide whatever data you have available and specify, on page 2, charac

Please tell us anything else that would help us to understand your indicator (e.g., list survey or MIS questions; describe linking methodology and data sources; specify time period for criminal justice involvement; explain whether treatment data are collected at admission, update or discharge; or evaluate the quality of your data). If you are now collecting data regionally, do you have plans to expand statewide?

Table 19B. Profile of Juvenile Justice Involvement

State: _____ Time period in which services were received: _____

Title of indicator: _____

Mark the option you are reporting in this table: __ 1)Arrests __ 2)Prison incarceration __ 3)Jail incarceration __ 4)Other (specify)_____

Mental health programs include: __ 1Youth with SED only __ 2)Other Youth (specify)_____ __ 3)Both

Time period in which juvenile justice contact was measured: _____

Source of criminal justice information _ 1)State criminal justice agency __ 2)Local juvenile justice agency __ 3)Mental health MIS
__ 4)Consumer survey __ 5) Other (specify)_____

Region for which data are reported: __ 1)The whole state __ 2)Less than the whole state (please describe)_____

	A. Total Number on Caseload	B. Number for Whom Data are Available	C. Number with Juvenile Justice Involvement	D. Consumer Juvenile Justice Involvement Rate (C/B)	E. Total State Population Juvenile Justice Involvement Rate (if available)
Total	0	0	0	0	0.00
Female				NA	
Male				NA	
Gender not available				NA	
5-9				NA	
10-14				NA	
15-18				NA	
19-21				NA	
Age not available				NA	
American Indian/ Alaska Native				NA	
Asian				NA	
Black/African American				NA	
Hawaiian/Pacific Islander				NA	
White				NA	
Hispanic*				NA	
More than one race				NA	
Race Not Available				NA	
Hispanic or Latino Origin				NA	
Non Hispanic or Latino Origin				NA	
Hispanic origin not available				NA	
Comments on Data:					

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethinic Origin are not available

Table 19C. Profile of School Participation/Performance:

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

This is a developmental measure. To assist in the development process, we are asking states to report any information they can currently provide with their December 2003 MHBG submission. Use multiple tables, as described below, if needed.

This indicator has two components: (1) school participation, and (2) school performance. If data for both measures are available, please provide one table for each.

These data may be collected using at least three different sources of information: educational records/databases, mental health management information systems, and consumer surveys. Please specify, on pages 2 and 3, the source of the data reported (circle responses or fill in blanks as appropriate). If data from more than one data source are available for your state, please provide separate tables for each data source.

Finally, data may be available for your entire state or for only some regions of the state. Please provide whatever data you have available and specify, on pages 2 and 3, characteristics of the geographical region(s) to which they apply.

Please tell us anything else that would help us to understand your indicator (eg., list survey or MIS questions; describe linking methodology and data sources; specify the threshold or standard of participation/performance; explain whether treatment data are collected at admission, update or discharge; or evaluate the quality of your data). If you are now collecting data regionally, do you have plans to expand statewide?

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 19C. Profile of School Participation

State: _____ Time period in which services were received: _____

Title of indicator: _____

Measure of school participation: __ 1)Percentage of school days attended. __ 2)Percentage participating in standardized tests.
__ 3)Percentage of time mainstreamed (not in special classes/schools) __ 4)Other (specify) _____

Programs include: __ 1)Youth with SED __ 2)Other youth (specify) _____ __ 3)Both.

Source of information: __ 1)State education agency __ 2) Local education agency __ 3)Mental health MIS.
__ 4)Consumer or parent survey __ 5)Other (specify) _____

Region for which data are reported: __ 1)The whole state __ 2)Less than the whole state (please describe)_____

	A. Total Number on Caseload	B. Number for Whom Data are Available	C. Total Number Attending School	D. School Participation Rate for Mental Health Consumers(C/B)	E. School Participation Rate for All State Residents (if available)
Total	0	0	0	0	0.00
Female				NA	
Male				NA	
Gender not available				NA	
5-9				NA	
10-14				NA	
15-19				NA	
Age not available				NA	
American Indian/ Alaska Native				NA	
Asian				NA	
Black/African American				NA	
Hawaiian/Pacific Islander				NA	
White				NA	
Hispanic*				NA	
More than one race				NA	
Race Not Available				NA	
Hispanic or Latino Origin				NA	
Non Hispanic or Latino Origin				NA	
Hispanic origin not available				NA	
Comments on Data:					

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethinic Origin are not available

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 19D. Profile of School Performance

State: _____ Time period in which services were received: _____

Title of indicator: _____

Measure of school performance: __ 1)Standardized test scores __ 2)Grade point average __ 3)% promoted to the next grade.
__ 4)Other (specify) _____

Programs include: __ 1)Youth with SED __ 2)Other youth (specify) _____ __ 3)Both.

Source of information: __ 1)State education agency __ 2) Local education agency __ 3)Mental health MIS.
__ 4)Consumer or parent survey __ 5) Other (specify) _____

Region for which data are reporte __ 1)The whole state __ 2)Less than the whole state (please describe)_____

	A. Total Number on Caseload	B. Number for Whom Data are Available	C. Total Number Meeting Criterion	D. School Performance Rate for Mental Health Consumers(C/B)	E. School Performance Rate for All State Residents (if available)
Total	0	0	0	0	0.00
Female				NA	
Male				NA	
Gender not available				NA	
5-9				NA	
10-14				NA	
15-19				NA	
Age not available				NA	
American Indian/ Alaska Native				NA	
Asian				NA	
Black/African American				NA	
Hawaiian/Pacific Islander				NA	
White				NA	
Hispanic*				NA	
More than one race				NA	
Race Not Available				NA	
Hispanic or Latino Origin				NA	
Non Hispanic or Latino Origin				NA	
Hispanic origin not available				NA	
Comments on Data:					

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethinic Origin are not available

Table 20A. Profile of Non-Forensic (Voluntary and Civil-Involuntary) Patients Readmission to Any State Psychiatric Inpatient Hospital Within 30/180 Days of Discharge

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 20A.					
Report Year:	2005				
State Identifier:	**NE**				
	Total number of Discharges in Year	**Number of Readmissions to ANY STATE Hospital within**		**Percent Readmitted**	
		30 days	**180 days**	**30 days**	**180 days**
TOTAL	0	0	0		
Age					
0-3					
4-12					
13-17					
18-20					
21-64					
65-74					
75+					
Not Available					
Gender					
Female					
Male					
Gender Not Available					
Race					
American Indian/ Alaska Native					
Asian					
Black/African American					
Hawaiian/Pacific Islander					
White					
Hispanic*					
More than one race					
Race Not Available					
Hispanic/Latino Origin					
Hispanic/Latino Origin					
Non Hispanic/Latino					
Hispanic/Latino Origin Not Available					

Are Forensic Patients Included? ◯ Yes ◯ No

Comments on Data:	

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethinic Origin are not available

Table 20B. Profile of Forensic Patients Readmission to Any State Psychiatric Inpatient Hospital Within 30/180 Days of Discharge

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 20B.					
Report Year:	**2005**				
State Identifier:	NE				
	Total number of Discharges in Year	**Number of Readmissions to ANY STATE Hospital within**		**Percent Readmitted**	
		30 days	**180 days**	**30 days**	**180 days**
TOTAL	0	0	0		
Age					
0-3					
4-12					
13-17					
18-20					
21-64					
65-74					
75+					
Not Available					
Gender					
Female					
Male					
Gender Not Available					
Race					
American Indian/ Alaska Native					
Asian					
Black/African American					
Hawaiian/Pacific Islander					
White					
Hispanic*					
More than one race					
Race Not Available					
Hispanic/Latino Origin					
Hispanic/Latino Origin					
Non Hispanic/Latino					
Hispanic/Latino Origin Not Available					
Comments on Data:					

Table 21. Profile of Non-Forensic (Voluntary and Civil-Involuntary Patients) Readmission to Any Psychiatric Inpatient Care Unit (State Operated or Other Psychiatric Inpatient Unit) Within 30/180 Days of Discharge

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 21.					
Report Year:					
State Identifier:					
	Total number of Discharges in Year	Number of Readmissions to ANY Psychiatric Inpatient Care Unit Hospital within		Percent Readmitted	
		30 days	180 days	30 days	180 days
TOTAL	0	0	0		
Age					
0-3					
4-12					
13-17					
18-20					
21-64					
65-74					
75+					
Not Available					
Gender					
Female					
Male					
Gender Not Available					
Race					
American Indian/ Alaska Native					
Asian					
Black/African American					
Hawaiian/Pacific Islander					
White					
Hispanic*					
More than one race					
Race Not Available					
Hispanic/Latino Origin					
Hispanic/Latino Origin					
Non Hispanic/Latino					
Hispanic/Latino Origin Not Available					

1. Does this table include readmission from state psychiatric hospitals?	☐ Yes	☐ No
2. Are Forensic Patients Included?	☐ Yes	☐ No

Extra Table: General/Additional Footnotes

Please use this table to enter any general comments and/or additional footnotes. This can be used for both footnotes that did not fit in the Footnotes field for a certain table ,or it can be used for comments that apply to several tables, or are general comments for a state.

Comment No.	Re. Table No.	Comment